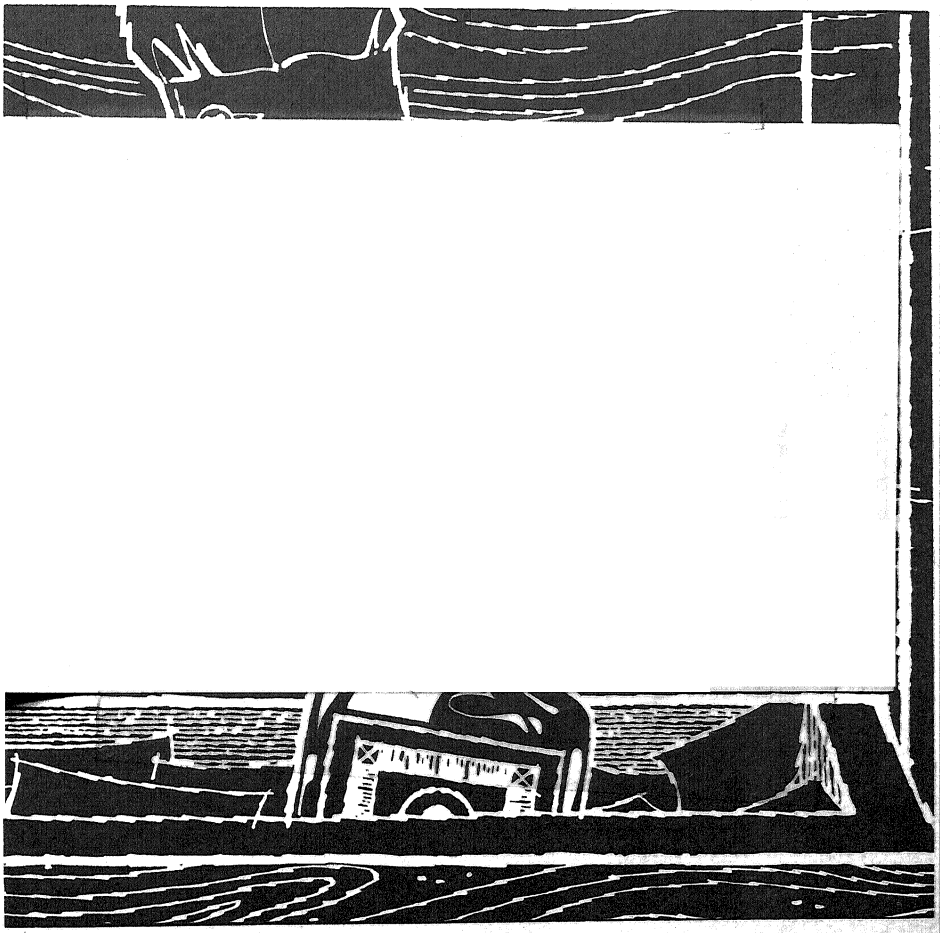
A Report
on a
Training
Conference

Alcoholism and the Federal Employee



Alcoholism and the Federal Employee

A Report on a Training Conference

April 1969

Washington, D.C.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Division of Federal Employee Health

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Foreword

On April 9 and 10, 1969, in Washington, D.C., the Division of Federal Employee Health held a two-day seminar on alcoholism for Health Unit personnel serving government employees.

The contents of this publication stem from that conference. Included are presentations of the guest speakers at the conference and an edited version of the question and answer and discussion periods which followed each talk. No attempt has been made to edit the thoughts of the speakers. Editing—such as has been done—has been undertaken only to clarify sentence structure or to cut out, in the case of discussions, repetitive material.

This publication is offered both as a study guide for occupational health personnel wishing to stage their own conferences, and as an overview of the beginning of governmental awareness of the problem of alcoholism and occupational health.

Introductory Remarks

Gordon S. Siegel, M.D.

(Dr. Siegel is Director, Division of Federal Employee Health. The Division, host at the Training Conference on Alcoholism, operates 73 occupational health units serving 125,000 Federal employees. The other primary responsibility of the Division is to consult with any Federal agency desirous of instituting an occupational health program for its employees.)

I want to welcome everyone here this morning. The Division of Federal Employee Health, Public Health Service, as you know, operates health units serving Government employees of various agencies. Some Federal agencies run their own health units. Some Federal agencies contract their health units out. So actually we have only a piece of the action.

For the past year we have been holding our own inservice training courses for Division personnel: our own nurses, physicians, and others. This meeting is one of our Division's inservice training courses.

It was set up primarily to train and orient the professional personnel of the Division of Federal Employee Health.

As usual, with our training courses, we tried to make some spaces available for participants from other Federal agencies that are engaged in running their own Federal employee health service.

Now, why this particular training session on alcoholism? There is a story, probably sort of a bad story, about the husband who comes home and finds a stranger hiding in the wife's closet. And he says, "What are you doing here?" And the stranger says, "Everybody has to be somewhere."

In dealing with the problem of alcoholism, you have to start somewhere.

As people working in employee health, physicians and nurses, we have all been cognizant that problem drinking, alcoholism, call it what you will, is one of the major public health problems in the United States, and it's one of the major occupational

health problems. Any time you have a congregation of individuals, problem drinking is going to be one of the health problems affecting this group.

Particularly in the work situation, where in essence you are taking a cross-section of the American adult population, alcoholism is one of the health problems that occupational physicians and nurses are faced with and that managers of work groups and fellow employees are faced with.

We all know that in private industry in the United States, there has been interest in problem drinking and in attempting to do something constructive about it through managerial, occupational health, union, and employee programs.

The Federal Government in a sense is "Johnny Come Lately" to this problem in dealing with it in some organized, constructive fashion. But that's not surprising. The nature of our Government is a check and balance system, and we usually move cautiously in most areas.

Certainly the Civil Service Commission has taken active interest in problem drinking as it affects the Federal work force; we have entered into an era where Federal employees, Federal managers, and we in Federal Employee Health are facing this problem, and seeing what can be done in a constructive way to deal with it. In health units of the Division of Federal Employee Health we have had in my opinion no very constructive way to deal with this problem in the past. Problem drinking, alcoholism, is always a touchy problem, particularly in the work force where an individual's livelihood hinges on the outcome of many activities that go on in occupational health.

I think what we have done in the past in our health units is to try to aid and assist individuals afflicted with this problem and aid and assist Federal managers and supervisors beset with this problem. We have done it sort of on a one-to-one or case-by-case basis, whatever the particular physician or nurse in the health unit might be able to do and was interested in doing and was capable of doing, but without any real guidance, direction, or training.

We'd like to enter an era of a more organized approach in attempting to work out a constructive program to deal with alcoholism in our health units in the Public Health Service.

How to go about it? Well, as I said, you have got to start somewhere. We decided a place to start would be to provide post-graduate updating, education, and training for our own professional staff.

How much our own professional staff knew about the problem of alcoholism was unknown to us. At least based on the knowledge of the headquarters staff, we all had a lot to learn and refresh ourselves on.

Not only that, we have to overcome the hurdle of trying to set aside whatever emotional or subjective preconceptions we have about this problem, and try to understand and deal with it in some objective, some professional fashion.

So it was decided that it would be valuable as a starting point in our Division to organize a training program, if you will, a post-graduate education effort, for our own nurses and our own physicians.

Since our Division has some 110 nurses and some 16 full-time physicians and many part-time physicians, we have to bite this off in pieces and chunks. This is the first group going through the first training effort.

So much for background; so much for introduction.

This particular inservice training effort was organized through the efforts of Mr. Theodore Chandler, the Chief of Information and Health Education of the Division, and particularly also Dr. Gustave Weiland, who is the psychiatric consultant to the Division, Dr. Stuart Lessans, who is in the office of the Chief of Clinical Services, and Miss Ada Murphy, who is our chief nurse for training. There are undoubtedly others of you who are due credit, and I want to thank you all.

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What Is Alcoholism? Sin? Disease? Habit?

Gustave J. Weiland, M.D.

(Dr. Weiland, a member of the psychiatric staff of the National Institute of Mental Health, serves as liaison officer between NIMH and the Division of Federal Employee Health, and provides consultative services to the Division on psychiatric problems seen in the Health Units.)

What is alcoholism? Should it be viewed from a moral standpoint? Should it be viewed from a public health medical viewpoint? Is it purely a legal, purely a social issue? Should it be seen as an administrative issue, something for the personnel department to simply handle in terms of annual leave, sick leave, leave without pay, all sorts of administrative machinery, to handle the person who is simply not doing the work?

Well, there are a number of reasons why I as a psychiatrist and as a person should be interested in alcoholism. I'm a member of the National Institute for Mental Health, and, as you know, NIMH has this rather grand task of promoting the mental health of the nation. And alcoholism and alcoholic problems do seem to have a great deal to do with the whole problem of the mental health of the community and what to do to promote this.

So we have a separate Center and we have a particular interest in it by all the members of the Institute.

As a physician I am bothered by any condition which accounts for something like 12,000 deaths yearly, and a condition which involves something like 3 percent of any work force.

These are men who are in their most productive years. Five out of six alcoholics are men in the years of greatest productivity from the age of 30 to 55. This is not an old man's disease. It is not really a degenerative disease. It is becoming more and more a young man's disease.

I am told that over the past few years the experience in AA and certainly among the medical profession is to see it occurring in a younger age group.

It certainly is a considerable hospital and clinic administrative problem. In the psychiatric hospitals nationwide it accounts for 14 percent of first-time admissions.

So it is a considerable statistical entity, something to count, something to watch. And it is something I think to be concerned with on a personal basis.

It has been called the billion dollar—or lately because of inflation the two billion dollar—hangover.

When I drive after midnight, I am increasingly aware that every mile or so there is someone on the highway who has been drinking too much and is a definite safety hazard.

So there are a great many ways of viewing the whole problem of drinking, and it brings a lot of different definitions. I rather like the World Health Organization definition as being a disorder of behavior. I think that takes it out of the tone of the moralistic point of view. It somehow gets away from the argument of just what kind of disease this is. WHO calls it:

> "Disorder of behavior, with repeated drinking of alcohol in excess of the dietary and social community norms, which is to an extent interfering with work or family or other social relationships."

And I think that is an important definition for you people in health units and working in various Federal agencies—to the extent that it interferes with work and other social relationships. This is I think your entree, your reason for concern about the drinking habits of employees.

I understand a considerable number of Americans drink. I would guess myself that the most reliable statistic is something like 70 percent. We're very much a drug and alcohol-oriented society.

I have heard the description of America as being so drug-oriented that we're in it, it's a part of our environment. It's very much like a goldfish swimming in water. I don't imagine if a fish could think as well as a human that he would be very well aware of water. It's as much a part of his environment as the air we breathe is of ours.

Alcohol is so much around us on our social occasions and our social practices that we become unaware of how much alcohol and drugs are available and used regularly by us.

I think you can agree with this if you think not only of the use of alcohol but of the use of tobacco, the use of coffee, caffeine, and the use of so many drugs to keep people going a little faster, to slow them down a little more, to relax, to relieve tension. For headache take aspirin; for tension take Compoz. It's becoming very much a part of the scene.

And what is it that makes it so much a part of concern in occupational health? Well, I think we might think a minute about how alcoholics come to your attention, how they come to the attention of personnel people.

Would anyone have any thoughts about how alcoholics manifest themselves in the health unit? How do they show up in your health unit as needing attention?

A PARTICIPANT. Usually a supervisor calls up and tells us he has a problem.

DR. WEILAND. Yes. And why is he a problem for the supervisor?

The PARTICIPANT. Because he interferes with the performance of other people.

DR. WEILAND. Yes. The work is not getting done in the office. And why isn't the work getting done in the office? Is he there 5 days a week? Is he the employee who is there 40 hours a week? Is he the employee that is working overtime?

I think not. Most often he's the missing employee. He puts in the half-day. He's half there when he is actually in the office. And so he's the one that rings up high usage of sick leave. He's the one that has to go on leave without pay. He's the fellow who is involved in the large percentage of accidents that show up in your health units.

It has been estimated that something like 20 percent of the people who have accidents are committing 80 percent of the accidents. So there is quite a tendency to repetition in accidents.

I think you will find that in your health units you will see every few months one or two persons who have most of the accidents of one kind or another, the falls, the cuts, the slips, the sprains, all sorts of things, which all interfere with their being able to work and to remain on the job.

These are the people who are achievement-poor, who aren't getting the work done in the office. So they become an occupational health problem.

There are certain things about their personalities which tend to keep them from fitting in very well in the office environment. Some of these characteristics are that because of the moral aspect of drinking they tend to be secretive. They tend to have to keep it somehow on the sly that they come rolling in late in the morning, that they get out early for lunch, that they come back late from lunch, that they have to chew chlorophyll or mint or somehow hide themselves from other people in the office and from the supervisor.

They have to keep out of things, and so they become very much out of things in the office.

They are the procrastinators. They are the people who don't get their reports in on time, who don't keep up to schedule with things.

In situations where finances and a petty cash drawer are available, they are the people who are the "till-dippers", the people who are always short of cash, borrowing money from other people in the office. And they are the people who run up the debts.

It's a part of the way they live that they are running behind, and they are running short in so many ways. They are running behind often with their alimony. They are more likely to be separated. They are more likely to be divorced. They are more likely to be in a mess in a lot of different ways, which creates a problem for the individual agency.

So these are some of the things that people with drinking problems do in the offices and some of the reasons for health units to be concerned about this, as well as personnel people.

But what to do about it? I'm quite convinced that the problem is not really so much how to identify someone with a drinking problem. All you have to do is get within range of them or work in the same office, and it's no secret. It has to be actively ignored or has to be worked some way that the work gets done despite their marginal participation.

So the problem is really how to handle these people.

Why is it then that doctors and nurses have a particular problem in handling and dealing with people with drinking problems? I think there are a number of reasons. Certainly doctors and nurses are not inexperienced in dealing with anxious people. This has been a part of the experience of each one of you since you got into the hospital for training.

You have dealt with anxious people before. Why this particular class of anxious people? Well, I think there are a number of things that are associated with how the alcoholic handles his anxiety. You find the drug takers who will abuse prescriptions and will take a great number of patent medicines, with bromides and all kinds of sedatives. Part of the alcoholic's experience is that he expects that he should be able to regulate the amount of anxiety and tension and discomfort that he should have to endure.

Now, he has a rather good way of doing it. Alcohol is an excellent antianxiety medication on the short term. It is a rather good antidepressant for the short term. However, as he becomes involved in the use of this potent food and drug, he soon becomes involved in a cyclical phenomenon. The more he drinks to make himself less anxious or less depressed, the more anxious and the more depressed he then later feels.

I know what first comes to your mind is the hangover after the night before. And, of course, the long term and very uncomfortable and profoundly unsettling phenomenon of the blackout, and the other unsettling happenings when one has been in the chronic alcoholic pattern.

But really I'm thinking more of the number of people I have talked to who have been drinking for a rather short period of time and notice that an hour after two or three drinks, instead of feeling better, they feel much worse than before they were drinking. There is this rebound of irritability and depression and anxiety which has a cyclical effect in prolonging and intensifying the drinking pattern.

So this is I think what is different about the alcoholic. He regulates his own anxiety, or attempts to do it, in some short term and ineffective way.

It is something that doctors and nurses are not used to encountering—a patient who is set on dictating the terms of his own treatment—and particularly in a way which is very frustrating not only to the helping people but to the drinking person himself.

There are certain feelings that the drinking person provokes, and I think if you would picture for yourself a moment someone in your agency who has been in to the health unit and the kind of feeling that he provokes in you and the other people in the

health unit you may be able to recall some characteristic feelings. How do people with drinking problems make you feel, make the other people in the health unit feel?

A PARTICIPANT. Disgusted most of the time.

Dr. WEILAND. Yes. They bring out disgust. Any other feelings?

The PARTICIPANT. Also sometimes you extend sympathy because they tell you their family problems, and you realize what they are doing to the family and also to themselves.

Dr. WEILAND. Yes, there's a lot of that. These people get you extending a lot of justified sympathy. You can feel a lot for them and for what's been happening to them. They disappoint you. They make you feel disgusted with them personally; as a helping person they disappoint and they disgust you.

The PARTICIPANT. And you don't feel you are reaching them. Because you tell them what you can do to help them and then provide this opportunity, and then they fail to keep the appointment. So you feel that you're not reaching that person. And I don't know whether we are at fault as people in the Health Unit or if it's the individual himself or herself.

Dr. WEILAND. Well, in any event, it's a very frustrating engagement. It's really a lack of engagement. You haven't really reached the person. The person lets you know that you haven't really reached him.

And, as Dr. Siegel has pointed out so well before, in agencies and in offices when this kind of frustrating communication pattern goes on for a little while and people haven't reached one another, the end result is indifference. People back off and say, "Well, this kind of thing isn't what I can handle. It isn't part of my job description, and it isn't anything we can do anything about."

So there is a kind of apathy and indifference. I think it's something that extends on both sides of the possible doctor-patient relationship.

There is a very pathetic victim image that comes out in dealing with this person. Some people say, and I think somewhat unsympathetically, that the person with a drinking problem is playing the old "wooden leg" game: "You can't expect anything from me. I've got a wooden leg. I can't be expected to do something about my family troubles. I can't be expected to keep

up with the work norms in the office. I can't be expected to meet schedules. I've got a sickness."

And I think this is what gets doctors and nurses backing off from the problem of the drinking employee. It's this: "You can't expect me to follow your directions. You can't expect me to do what would be sensibly helpful to me."

There is a great feeling of inferiority that is expressed: "I can't handle. I can't do. I can't be expected to do." And yet, on the other hand, I think there is a feeling of self-sufficiency which the person with a drinking problem puts to you which is another way of putting off and putting at a distance the potential helping people. I think this feeling of self-depreciation is an important part of it.

So along with the pleasure-seeking aspect or tension-relieving aspects of the drinking pattern, there is a great and contradictory tendency to avoid help, and, further than that, to inflict trouble upon himself. It's really a vicious cycle.

There is the demanding, indulgent side of it, and the great frustration of the helping person. You know, "I've got to have relief of my anxiety and tension. You can't give it to me. You haven't been able to help me in the past, or you've tried to help me with medication, or with advice, or with referral, but that didn't help. I wasn't welcome there. They couldn't help me."—this kind of thing which leads to a kind of disappointment and rage in the parties involved.

And so then a kind of hostile indifference results. And along with that, for the person with a drinking problem and especially so for the professional person, there is a feeling of guilt and self-castigation. "I should be able to do something about myself and this drinking problem." And the professional person, "I really should be able to help that fellow somehow, and yet he won't let me."

Often, after this backing off, there is again a coming together with some reassurance, some feeling of acceptance, and then the cycle goes off again, the demands, the frustration, the mutual hostility. It's a very unrewarding and unproductive and unsatisfying experience.

This sounds all very pessimistic. But I think it need not be so. The need here is for some degree of objectivity, some degree

of professionalism, some degree of development of one's professionalism.

Dr. Siegel has put it quite well in pointing to this need to be objective and to develop professionalism on this topic.

I think it is quite likely that the outcome can be much more satisfactory if this can be developed.

The thing to be kept in mind for the doctors and the nurses is that a problem about this is that doctors traditionally see it as a very unusual disease. Alcoholism certainly won't satisfy Koch's postulates. And there's probably no other disease that you can think of which can be treated by conditioned aversion, by simply avoiding and forcing the avoidance of the alcoholic indulgence.

So it's a rather unusual disease and has led to a great deal of dispute about whether or not it actually is a disease. I think many people will agree that it is a symptom, and it is a symptom that is developed to the proportion that it is a medical disease problem.

I think nurses—particularly—in addition to the problem of the doctors—need to realize that these are people who are difficult and demanding and who arouse strong feelings of disgust and disappointment. They can be expected to arouse hope and to arouse disappointment, and the chance of affecting the outcome somewhat is largely dependent on your ability to establish some objective and less personally involved stance.

A PARTICIPANT. Doctor, don't you feel that we have to deal with our own anxieties about our own drinking that are reflected as we try to deal with these people?

It reminds me of how I might become this way, and I think I can really put up some defenses which constrict my objectivity in dealing with these people. They threaten my drinking.

Dr. WEILAND. Yes. I think that's an enormous part of the difficulty in dealing with the drinking employee. Because the great majority of us drink, we have many conflicting feelings about drinking which is a part of our society and a part of ourselves. However, there is a positive aspect to this, and I think it is related to the saying that every surgeon should have a surgical scar as a part of his training.

I think one of the meanings of this is not only just seeing the whole process of surgery from the point of view of the patient, but being able to empathize with the surgical patient in a differ-

ent way, having had that kind of difficulty. If we can be aware of this; if we can be aware that perhaps a person with a drinking problem is not too different from us in our difficulties in controlling smoking or controlling overeating, we can see that there is a great deal of common ground here.

A PARTICIPANT. May I add that I have had the experience of trying to promote programs for alcoholism in business and industry, and I have found recommendations stalled on particular desks in the executive echelon. And I find that this is the man who sees that he might become the first patient and will block the development of such a program because he's afraid of his drinking experience.

And I think this is a critical matter in trying to develop the program within an organization.

Dr. WEILAND. Yes. It's all part of the wider problem—how to deal with this in some sensible, strategic sense within your agency.

The PARTICIPANT. In my particular situation oftentimes I know of the problem because it is brought to me by other employees, but the person who is really having the difficulty avoids the health unit. The coworkers will, when he gets into difficulty, get a cab and take him home. He never gets into the health unit situation.

Dr. WEILAND. So how to deal with the person who doesn't come to the health unit as a patient? This is a considerable problem.

I think you'll see this with other types of emotional problems, and I rather feel that it's related to the kind of welcome and to the kind of resources which the other people in the office believe are available at the health unit.

There is a great pessimism generally in the community about alcoholism and what can be done about the employee who drinks. So I think you will find that they are not going to bring him to the health unit because they fear he will then go to the personnel office and then he will be fired.

This is an unreal fantasy, because the personnel office is itself struggling with knowing about more people who drink than they can deal with, than they can tell their managers and supervisors how to manage.

Dr. SIEGEL. I think you touched on a very important area that is usually not discussed even in a professional meeting such as this, the anxiety on the part of the physician and nurse, which I think is related to a fear of failure in being able to deal with this particular type of health problem.

Even though I think as physicians and nurses we realize there are many diseases and illnesses of which we will not be able to influence the outcome, at least usually we are hopeful or we try. But alcoholism is one area that I think engenders a tremendous amount of anxiety, because from the beginning we feel that we are doomed to failure, and it makes us very anxious, very unsure of ourselves.

And maybe this area is almost unique in producing this kind of reaction among physicians and nurses.

I know that's what bothered me when I had alcoholic patients that I had to deal with in a clinical situation. And I began to analyze: Why the great difficulty? It was tremendous anxiety on my own part. They were threatening me professionally. I was going to have to admit or be forced to show that I couldn't deal with this situation. I really didn't know how to deal with this situation.

And when you threaten a professional on his professionalism, you make him very, very anxious.

Dr. WEILAND. I'm glad you didn't really ask that as a question, because I don't have any good answer to that kind of situation, except to suggest sharing the problem with other professionals who can help to deal with it somewhat more adequately.

I can share with you my anxiety as a physician and psychiatrist and tell you that psychiatrists generally are not particularly helpful about curing alcoholism. When I have a patient referred to me because he is an alcoholic, I get that sinking feeling, and then I think, "Well, now, what within this is at all workable?" In other words, I'm already thinking in terms of the physician who is confronted with late-stage carcinomatous disease. I have that kind of feeling. What can I do that will be in any way remedial? What can I do that will be in any way hopeful in the situation?

You know, if I get a different kind of story and I am told that this is someone in the midst of a depression or who, to control irrational fears, has begun to use alcohol, all of a sudden I have

a different feeling about the therapeutic situation. I feel it's workable. I feel that something can be done.

But if I am told that this is a problem of long-standing behavior habit, I realize that this is a hard thing to deal with, and I'm not as hopeful.

Dr. SIEGEL. I think both of these points bear on why people aren't brought or don't come to health units. And this is an area that we will have to dig into and work on in our health units.

And it relates too to the question on policy. It's anxiety-producing not to have an organizational policy. But I have come around to sort of thinking that even in situations where we can't get organizational policies, we will make a health unit policy and disseminate knowledge about what the health unit policy is going to be and how we're going to handle people with this problem.

Dr. WEILAND. Yes, I think you will have to resign yourselves to the fact that you will be dealing in an unclear and ambiguous area where people are not rushing forward to take responsibility for action.

A PARTICIPANT. I had a lady who came in for a minor illness. I think it was just a cold at that time. And in the course of conversation she told me that she was a chronic alcoholic, but was not drinking at that time. She had stopped drinking 6 months previously.

And so in the conversation I said, "Well, if you have a problem, come see us before you start drinking."

Two weeks ago she came in, and said she had had her first drink that morning at 8 o'clock and she needed help. She told me that she was going to group therapy at the D.C. Mental Hygiene Clinic. So I called her caseworker, and she said that they would see her at 11:30 that morning. Well, since that time I have not seen the lady, but her office told me that she had tried to commit suicide later on.

But when she saw me that morning she said she was very depressed following her meetings. This was in the group therapy clinic she was attending. And she felt she was deriving no help from these sessions; she came away more depressed than when she arrived at the meeting.

Dr. WEILAND. Dissatisfaction? Rage?

The PARTICIPANT. Yes.

Dr. WEILAND. An inability to handle and contain the rage and a great feeling of wanting out of the situation. And I think this is the suicidal potential of these people. And it's a difficult problem to deal with.

I don't think I mentioned another particular problem that medical personnel have in dealing with the referral to Alcoholics Anonymous. AA has a marvelous way of dealing with this by asking that the person identify himself as an alcoholic with a drinking problem that no one can really help but the person himself.

Now, this is a marvelous approach and has been effective with a large number of people. But I think the fact that AA was started—although there have been medical people involved from the very beginning—in a nonmedical context and has remained in a nonmedical context brings about difficulty with many medical personnel not only in arranging referral but in continuing followup. And this is a tremendous gap which is hard to bridge.

It is easier for you to say, "Get in touch with the D.C. Hospital and the group therapy person there," because it's still in medical channels. But I think the other problem has to be considered too.

A PARTICIPANT. I think the development of an agency policy statement is helpful, but it's not exactly 100 percent of the problem's solution. Because after you get the statement, you have to get employee acceptance. Many times they will say, "Oh, yes, that's a good policy, but I don't believe it."

So the development of an agency policy per se is just the first step, in my opinion. You have to have a program to back it up and to prove to the employees that you really mean what you say.

Dr. WEILAND. Yes. And speaking of programs, this means that you may have to begin a new relationship with some of your personnel people, some of your administrative people, to work out and put into effect a program or policy.

The PARTICIPANT. I think not only should we conduct training programs for the health unit staffs of nurses and doctors, but also I think the Civil Service Commission should get involved in training the supervisors on what will be available through the Government, what will be done for alcoholics. Because the supervisor oftentimes is really the one who will direct the em-

ployee to the health service if he knows something can be done through the health service.

This is one thing that has not been developed in many of the agencies and departments.

Dr. WEILAND. That's very good, and that would fit in with the whole pattern of reciprocal training agreements for executives with the Civil Service Commission.

Dr. SIEGEL. Could you make some comment, Dr. Weiland, on the propaganda of alcoholism as it is being given now to the general public? What is the general public's expectation of what physicians and nurses can do in alcoholism and the kind of conflicts or difficulties that this might cause to the professional person?

I think in setting up this meeting, we wanted to place emphases on understanding alcoholism as it affects the physician and the nurse. And I think what the public expects from a physician and nurse is part of the picture.

By the public, that includes the work force of the particular location.

Dr. WEILAND. What are your other reactions on this? Have you had unrealistic expectations from the viewpoint of the medical education on alcoholism as a disease?

I felt that it has worked against me as a therapist with patients, when patients say, "Well, you know, I've got trouble with drinking," as though then, "Now, what are you going to do about it?"—as though, well, alcoholism is a disease and what kind of penicillin do you want to try on this?

And, as you all well know, drugs like Antabuse and Temposil aren't for everybody. They are risky drugs. They work for a few people who are extremely reliable with drug usage, which people with drinking problems by and large are not. They are reliable for people who are compulsive in a certain way and cooperative with a medical regimen in a certain way.

So they are really helpful for very few people. And I think the expectation is that there's going to be an Antabuse, a magic pill from the physician, and there isn't; not from any doctor or nurse.

Dr. SIEGEL. How do you communicate this to the patient?

Dr. WEILAND. How do you do it in your health unit? How does it come up?

A PARTICIPANT. I use the concept of illness to try to relieve their self-deprecation and their shame. I relate it rather awkwardly to, "This is not unlike the deficiency disease, diabetes, and in a great sense it's not your fault." I try to give them some relief and comfort to be able to get to talk to them.

Then I proceed to try to show the difference: "This is not an ordinary disease. There is no medicine that can help you, but this is a matter of your trying to find out how to live without alcohol, how to deal with your life without alcohol."

But the concept of disease used to relieve their shame is a great asset.

Dr. WEILAND. And it's not only to relieve shame, but I think, also to insure acceptance. People aren't brought to the health unit because of their drinking; people don't see drinking as something which is treated by doctors and nurses. The concept of alcoholism as a disease indicates that doctors and nurses are interested in treating it.

But I think that's a very good approach of describing the difference between, say, the drinking problem and appendicitis in which someone can be brought in, anesthetized entirely without his cooperation, and operated on in a curative way.

Then you can think of so many different diseases, everything from appendicitis to sinusitis, which operate in an entirely different way, and are more chronic, more of a disease which can be worked on with the cooperation of the patient and one which depends in great degree on the resources, the assets, the favorable life situation and other aspects which can be utilized by the patient to help lick his disease.

Someone who can't afford a proper diet can't alleviate his diabetes. Someone who is very favorably situated is more likely to be able to have favorable outcome of the disease and of the alcoholism.

A PARTICIPANT. If a person goes to some referral source, some clinic or individual doctor, or whatever, if we have been lucky—and I use that word—if we have been lucky, he goes not saying, "Give me a nostrum, give me penicillin," but he goes saying, "What can I do that you can help me out with?"—rather than "Help me!"

This is where I think the health unit is of service to the professional who wants to get the best help he can even from way down the line.

Dr. WEILAND. I see that as part of the treatment, because it is so important and so much assuring the long-term result—that you begin to prepare a person to look at his illness, look at his difficulty, in a certain way.

In other words, I don't see anything particularly contradictory in the AA scheme which goes about it in a different way, which throws each alcoholic back on his own evaluation of himself and on his own resources, to some extent, on his own will to recover.

And the other contradiction is that they supply so much in the "good samaritan" approach in their support. So they offer something in a different way.

But I think there is tremendous usefulness in the doctor and nurse preparing the person for treatment, and I think it is a part of a good start for treatment.

The Dimensions of the Problem in Occupational Health

Harrison Trice, Ph. D.

(Dr. Trice is a professor at the New York State School of Industrial and Labor Relations of Cornell University. He has written prolifically on the problem of alcoholism in industry.)

Your chairman asked me a moment ago when I came in a few moments late if I wanted to be introduced as "doctor." I told him that I think it would be better if he called me "professor."

I say that because my teen-age daughter, who is now going through the throes of that transition period, recently answered the phone when someone said, "Is Dr. Trice there?" and she said in a facetious moment, "Yes, he's here, but he's the kind of doctor that doesn't do anyone any good."

So since then I have decided to be called "professor," which seems to fit a little more what I do anyway.

My major activity is largely research. I don't know whether you have any specific content of that word "research." It's a many-splendored word meaning many things to many people.

But as I was sitting here a moment ago listening to your discussion, I was attempting to see if perhaps some of the prepared statements that I had made might not be altered a bit and some of the research that we had done in the past might not be put a little closer into the context of your discussion.

As I get one of the main drifts of the points that many of you were making in the interchange, you were interested in treatment and treatment results, whether they be by way of referral or by way of what you do as medical personnel. And I think this fits somewhat by way of introduction.

We have done a great deal of research in the area of the impact of alcoholism and other behavior disorders.

If you look at the depressive disorders, I think they have a sharp impact on the work world. I don't want to build alcoholism up as some predominant phenomenon in the work world.

In our research we have discovered that the impact on the supervisor, on the nurse, and on the medical department seems

to be greater from the alcoholic employee than from either the psychotic or the psychoneurotic, using those in their broadest connotation.

But I thought that it might be more interesting for me to briefly discuss some of our research activities regarding the evaluation of therapeutic efforts and the evaluation of training efforts. To me, these two things are really very similar.

We have recently conducted a very large study trying to evaluate the effectiveness of training supervisors about alcoholism and other problem employees or therapeutic efforts regarding the alcoholic employee. I think these are in many ways quite similar, in that they change actions allegedly, and you can try to evaluate them.

In any event, let me give you some of the circumstances under which therapy appeared to be the most effective.

We might preface this by saying that as we attempted to evaluate three or four different therapeutic approaches, we found that any one of them produced results. In other words, I think it's possible for you to say that if you take a random sample of alcoholics and submit them to psychotherapy of some persuasion but within the psychotherapeutic ideology or origin, you will discover that you get a sizeable amount of response. Fifteen, 20, at least 25 or 30 percent will respond.

If you take just the opposite, a somatically-oriented therapy, such as conditioned reflex, you will also get a sizeable amount. But apparently it never gets much over 25 or 30 percent.

Alcoholics Anonymous, as much as I love it (I have had the privilege of serving on their Board of Trustees for the last 15 years), never gets much more than 15 to 20 percent of the population, regardless of how often they are exposed, because there is a selective process going on.

So I think that any treatment get results. Unfortunately, the big problem is to up the results.

Just let me describe in the work world situation the kinds of circumstances in which these results have moved up very sharply.

When an organization—I don't care whether it's the government, whether it's an esoteric small industry, or whether it's a large utility; I don't care what type it is—has a substantial program, if that program and policy are operative and if there is a relatively earlier referral, recognition or treatment—I did not

say "early"; I don't think there is such a thing—and if there is realistic confrontation by line supervision in terms of work performance, response to therapy goes up very sharply.

I think I'm a fairly cynical statistician. Yet I am ready to accept the results of a sizable number of these work-based programs in which, by reasonably good followup and fairly careful evaluation, almost 50 percent success has been attained. It was due I think to the presence of a very realistic policy which had in it the provisions for crisis precipitation.

Secondly it has in it the kind of training that was realistic to supervisors but which set the stage for earlier recognition.

And I think it was characterized by realistic confrontation by line supervision on the basis of poor job performance.

If there is any one thing we know about the developing alcoholic, it is that his condition begins to impair role performance. As a matter of fact, as a sociologist, that is my definition of alcoholism.

As sociologists we deal with roles and the performance of roles in organizations. And when people have a series of expectations which they are going to fulfill to perform that role and they do not do it, then we speak of them as being deviant. And certainly this characterizes the developing alcoholic.

We have a vast amount of basic, solid evidence to demonstrate the extent to which there is clear-cut role impairment, and to the extent that the organization policy provides for the proper kind of training and support. It's one thing to have a policy. It's one thing to implement it well with staff people and with top management. It's quite a different thing to overcome the gap between there and line management.

It's not too difficult, however. It has been done.

If, however, it is present sufficiently so that the supervisor does realistically confront, then the treatment resources have delivered to them an individual that is more motivated.

I could describe to you briefly the studies we have done of dropouts in community clinics. Why is it that people come to the clinic two or three times and never come back? They are not put in that kind of crisis bind which says, basically, "You are going to have to realize that the payoffs from alcohol are no longer there."

Alcohol has worked for the alcoholic—much as it may sound strange to us, it has worked for him emotionally. He has managed to do a whole series of things in defense of his drinking, and they have worked.

Not only does alcohol do a lot for him in his emotional makeup, but he has learned ways of managing people who attempt to get him to stop.

He is a Ulysses S. Grant and a Robert E. Lee combined, if I may exaggerate—an excellent field general, and an excellent manipulator. He's been doing it for a long time.

He can do the same thing to his boss he does to his wife. He snaps out of it, snaps out of it beautifully 3 or 4 or 5 or 6 weeks, makes his wife queen for a week, makes his boss feel like a dirty stinker for having thought of referring him to the medical department or personnel, or of using discipline.

Until there is a realistic confrontation that may produce a crisis, we will never make much headway in the efforts to do something realistic about alcoholism.

I have questions about the word "disease" or "illness." But if we use it, let's make sure we say the word "unique" in front of it. Because alcoholism is a unique disorder, unique in that until the alcoholic faces a clear-cut crisis in terms of the use of his drinking, we have very little chance of producing the kind of changes that we want to bring about in therapy and treatment.

One of the best places, in my judgment, to produce those crises or realistic confrontations is in the work world.

Having watched a lot of spouses try to face reality with these individuals, I am convinced it doesn't come from there.

But I have seen a lot of union and management people, foremen and supervisors, who got fed up to the gills and who said, "Look, it's not your drinking we're talking about. That's your private life. But we have every reason to intervene because your performance is no good. I'm sick and tired as the shop steward of finding some way of making up your absenteeism. And you are a stinking griever. You have caused me more trouble. Even though you are a nice guy and we have loved you, the end has come."

The supervisor basically in realistic confrontation says, "Look, it goes like this: First, I never know what to expect from you, even though you are a good man and in the past have been a

good man. Second, I'm always looking for replacements for you. Third, you put me in a bad light in many instances."

We could go on with a series of these. I can provide you with the research data. This is the combined expression of supervisors and union shop stewards in five different companies in large organizations. And they basically have a potential for confrontation, even though the potential is at times wishy-washy, and supervisors definitely go through a vacillation.

A point I would like to leave with you is that the potential for this kind of realistic confrontation is probably the greatest in the work world. And until that reality comes out in the open and is set clearly on the table for what it is, we have very little chance of making therapeutic headway.

I think that we can add to this the fact that in terms of earlier recognition this occurs in the work world probably as soon as any place.

It is a myth to believe that the alcoholic is hidden. He is not hidden. He may be hidden from high staff people. He may be hidden from top management people. But the people who work with him know it, and they come to know it pretty fast. They don't come to attach it right away, and they are wishy-washy, and they vacillate, and they will go through stages.

The point is again that the potential for confrontation, for crisis precipitation, and for earlier recognition is there in the work world. And if we can take advantage of it, I think we have put the alcoholic in the kind of situation where, when it reaches you, you have some chance.

That's what all the data is telling us. He is still intact in job and family. He is realistically confronted—and, if necessary, crisis is produced.

Incidentally, it has been our experience that alcoholics invest an awful lot in the job. We all invest a lot in the job, even though you may not emotionally get a lot out of your job. Your professionals do I'm sure. But even at many job levels there are fringe benefit investments. There are all sorts of investments. It's the last bastion of defense for many alcoholics.

Any time he can bring the paycheck home, he can shut his wife up in a big hurry. And I have seen that happen many times.

The job is the last bastion of defense. And when it begins to

crumble, you have a real chance of getting in and working v a responsive person.

Now, if we take a look, for example, at the statistics regar individuals who have reached the stage of being in State me hospitals we do find results, but never much over 20 percent.

Or if you come down to the stereotype of the alcoholi American society, skid row—We seem to be obsessed in society with skid row. I can't understand why. It doesn't m up more than 5 or 6 percent of the alcoholic population to b with. And yet if you look at some of the major endeavors in field today, you would find that vast proportions of our resou and funds are being aimed at that 5 percent.

The alcoholic typically is still working, typically still in a still in a family, still intact. This is the reason you people ar important. Because you are the people who really count in area of alcoholism.

It's not the welfare worker, as much as I respect her. It's the judge down in municipal court. It's you people. The where the chance really is.

When we evaluate the therapeutic efforts that are mad the skid row level, if you get 5 or 10 percent results you are re lucky. I have the greatest respect for those herculean efforts. they're not going to get anywhere.

Suppose they do get the five out of a hundred. That's won ful. But it's going to do very little for the basic public health p lem that is alcoholism. Whereas if you deal with it in the v world, you have these advantages and these factors involved.

These are just some of my responses quickly to the discus that was going on here. And I couldn't help but feel that I c tie in to those a little bit with respect to the work world.

I know when I first got out of the service during World Wa I was very conscientious, and I used to write out my lectures read them to students at 8:30 in the morning, and I was al somewhat puzzled as to why they went to sleep. I thought had a fairly good night's sleep.

I had an old uncle who was an emeritus professor, and I a him if he would come around and tell me what he liked a what I did, which he did one morning.

He said, "Well, son, there are three things you did wr

First, you read it. Second, you didn't read it very well. Third, it wasn't worth reading anyway."

So I haven't read anything to anybody since.

Let me address myself to the formal letter here. I was to talk about the dimensions of the problem in occupational health. And, by the way, I like that word "occupational health." If there is anything that I have encountered as a professor working with industry and work organizations over the years, it's their rejection of these designations like "alcoholism."

Now, I know people in the alcoholism field don't exactly like me when I say this. But, as I say, I'm not in the alcoholism field. I'm in the field of industrial labor relations.

The simple truth is that you have to identify this with other health problems.

The people in the alcoholism field are scared alcoholism will get lost if you don't spotlight it. I don't think it will. It plays a prominent role in the problem. Yet it never affects over 3 or 4 percent in any organization—maybe 5 or 6 percent in some and down to 1.5 or 2 percent in others.

There has been a lot of statistical ballyhoo. I hold the line fairly firmly. Somebody has to prove to me that the current evidence is wrong—that there's 10 or 12 percent in a typical work force.

If you get a unique company that is made up completely of Irishmen, all men, between the ages of 48 and 60, who are in a huge metropolitan district you can probably get the rate up to 6 or 7 percent.

But if you just take the opposite, as many government units do, where you have almost an equal sex ratio, you can't start stampeding this notion that we are just rampant with alcoholism.

I tried that once over in Baltimore 10 or 12 years ago and learned my lesson. I scared the hospital administration out of their skins, and instead of opening the doors for alcoholics, they slammed them shut against the flood which they thought was imminent at any time.

So I want to make it very clear that in terms of the dimensions of the problem it centers around 3 or 4 percent. And, after all, there are other problems.

The problems of the depressed employee which we have been looking at lately strike me as certainly of as great an impact as is alcoholism.

That I think is the first dimension of the problem.

A second point that can be mentioned here is that the alcoholic continues to work through most of his disorder. It is not a case in which his illness comes on very quickly and reaches a climactic stage and then in one way or another either gets much worse or improves. We have found in studying a series of the phobias and other forms of the psychoneuroses as labelled by company psychiatrists in two or three large companies in New York City that alcoholism was a much longer progressive disorder, covering a much longer span. The absenteeism that characterizes the developing alcoholic clearly shows this.

If you compare his absenteeism in retrospect to persons who have been diagnosed as psychoneurotic or even psychotic, you will find his absenteeism is much more chronic, whereas the other two are much more precipitous. It suddenly goes zooming up and drops off, whereas the alcoholic's is just way up over a long period of time.

So basically, the alcoholic continues to work.

He is concentrated largely, as I said in the male category. If you look at national epidemiological data, alcoholism still remains a breadwinner disorder.

Furthermore, it is age-concentrated. If it were somewhat more distributed in age, as were some of the other behavior disorders, it would have less impact. But it is clearly concentrated in the productive years, the mature years, those years of 35 to 55, in which the individual is expected to make the major contribution to his organization.

It is not class-concentrated as many people think. Some of the basic data we have indicate that it is spread quite evenly across the various occupations and across the various social classes, in contrast to such severe disorders as schizophrenia.

What this says in practical terms is that your executives, your professionals are just as apt to fall prey to this disorder as are your janitors. This is clearly a fact which I believe we can tentatively accept, although the research data in my judgment is not as good as it should be.

Now, when you look at the job impact, there is beyond doubt a sharp impact on work efficiency and work effectiveness.

This varies with respect to job level. If you are a top manager, your work efficiency declines in a much different way than if you are a guard in this building. It is much more cyclical at that level, and you work in much more severe spurts and starts. In the spurts you are very, very creative, and for a period of time certainly you are not visible because of your intense ability to cover up.

I think we can summarize by saying that, regardless of the occupational level, there is sizable evidence to show a clear-cut job impairment. And, as I said a moment ago, from the purely sociological standpoint that is the definition of alcoholism. It is the impairment of central roles, the recurrent use of alcohol to the point that it impairs specific central roles.

At that point I think that you can cut through a great deal of the clinical confusion, and certainly you can communicate with people in the work world with that very simple definition.

When you come to absenteeism, as I mentioned a moment ago, there are many kinds of absenteeism that the alcoholic has invented. Not only does he have off-the-job absenteeism, he has on-the-job absenteeism. That may sound a little strange to you at first, but certainly it isn't, I think, too far-fetched.

First, he has a lot of partial absenteeism at work. He comes to work, but he disappears. You can't find him. He is extremely adroit even under highly scheduled conditions in finding ways of being away from his post.

There is a whole series of "no report," and that begins to characterize the alcoholic.

Again, if you study the way absentee patterns run in large organizations, you inevitably discover he is associated with no report. He doesn't report. He doesn't call in. He doesn't let anyone know. That becomes a part of that tremendous headache that I was talking to you a moment ago about as far as the supervisor is concerned.

In any event, we can clearly say that, regardless of the kind of absenteeism, off-the-job, on-the-job, or other varieties, the alcoholic certainly ranks very high.

Where accidents are concerned, oddly enough, the myth that he has many on-the-job accidents is not correct. He does not.

One of the main reasons is that he is protecting the job. The job is in many ways his last bastion of defense, his last justification for his drinking.

Consequently, on-the-job accidents are not nearly as high as you would suspect. The old notion that he is constantly producing the major accident rate is certainly erroneous.

I think there are two or three interesting reasons for that. One is the one I mentioned a moment ago. He becomes extra cautious and wants to defend himself from spotlighting. Another factor is his absenteeism. It's very difficult to have an accident if you're not there.

By the way, we discover that he does have accidents, a sizable number of accidents, but they are off the job, and they are relatively minor. For example, one large study out in San Francisco shows that out of about 150 fatal accidents by alcoholics, only two occurred at work. The rest were elsewhere.

People often talk about the coverup at work. The coverup at work does occur, but it seems to have three major characteristics to it or three major types. One is self-coverup, the individual doing all the covering up of his drinking himself and the response to his drinking. This occurs mostly at the higher levels.

We have case histories of presidents of companies who have gone all the way through their alcoholism and no one ever knew it except an extremely small coterie of persons that surrounded and protected them. They engaged in self-coverup at a tremendous rate.

You get coverup that stems from associates, fellow workers. This occurs more in middle-level occupational statuses where the coverup is largely performed either by the developing alcoholic or with the immediate help of a work group.

For example, in studying large construction gangs and groups, we discovered that the specific work group did a great deal of the basic coverup. They knew about the developing drinking problem and were acutely aware of it. But they would shift the individual around at certain times. They would fill out his time sheet for him; a whole series of things of this nature.

When you get down to the lowest occupational levels, you find that many times there is no coverup at all, just very open drinking. You get into the occupations that make up our lower statuses, and there is no such thing as coverup. That, of course,

is the reason that we identify in the work world the lower status occupations first. And this is what typically happens.

The data clearly tell us that the likelihood of the janitor becoming an alcoholic, being identified, and being referred, is much higher than the executive director.

So much, I think, for turnover. That is a job behavior. We find that alcoholics aren't job hoppers either. If you again focus on the skid row alcoholic, as has so often been the case, sure, you find job hoppers. But when you compare by occupational level the alcoholic with the nonalcoholic, you find the alcoholic supervisor is going to be with you for a long time.

Firing is a myth to a degree in the work world these days. You don't fire these guys. But firing especially if there is a union around, is something that is becoming more and more antiquated and almost unheard of in two or three large industries in which I have worked—for the very simple reason that it is almost impossible to secure that kind of discharge through the union apparatus.

So the upshot is that the company keeps its alcoholic employees.

So much for the demography of the matter from the job standpoint.

We covered age concentration, sex concentration, the number of persons typically in the work world situations. We covered social class concentration. Then we have looked briefly at job impact.

The supervisor seems to go through what we might call approximately four stages of response to the alcoholic employee. We have studied a sizable number of supervisors who have been the bosses of developing alcoholics, and through a series of other data it seems that we can describe what we might call four different phases.

The first one would be the disrupted but normal stage. During this period a whole series of job disruptions occurs because of excessive drinking, but the supervisor manages to stretch his definition of normalcy and hold on to it. In other words, there are no dramatic symptoms in these early phases.

The main thing that happens is something inside the developing alcoholic which he manages to cover up fairly nicely. Minor hand tremors, increased nervousness, hangovers, avoid-

ance of the boss and work associates, morning drinking before work; many of these things begin to cover up the pattern of his suffering, because he is suffering a good deal.

And he presents to his supervisor a relatively normal but at times more disrupted than usual pattern. So we can talk about the phase that is disrupted but still normal from the standpoint of the supervisor.

The second is what you might call the blocked awareness stage. It is the period in which the supervisor becomes acutely aware that this impairment which is beginning to pile up now is due to drinking, and he becomes acutely aware of declining quantity and quality of work and a noticeable spasmodic pace in many instances.

He is aware of it, but a whole series of things prevent him from doing anything about it. One is that numerous jobs have low visibility.

In one large company we studied, we discovered that the alcoholics that received the latest treatment were in mobile jobs, jobs that had relatively low visibility.

Then a second reason, of course, is the status level of the deviant drinker. If the deviant drinker has substantial power in the organization and higher status, there is less tendency to respond to his disruption.

In one large utility, we discovered that if the employee was middle-class white-collar, there was far greater reluctance. The supervisor just didn't believe a guy like that would act that way. But he was very, very ready to say, "Oh, the janitor is a drunk."

So even though he begins to realize impairment of the job, even though this impairment begins to pile up and mount, he still is very reluctant to do anything about it.

And then there is a sizable degree of tolerance for the deviant drinkers. Alcohol in our society is both red and green simultaneously. We have a fantastic amount of ambivalence about its use.

One of the startling things we have discovered in working with a lot of supervisors and shop stewards and work world people is the extent to which they will normalize these deviations, find reasons for saying, "Well, yes, we know it was disruptive, but we are going to put up with it because if we did anything,

it would be more difficult than just going ahead and putting up with it." A high degree of tolerance.

And, finally, I think that there are various procedures in the organization itself that make the supervisor very reluctant. One of the most obvious ones is the discipline procedure that governs unionized companies. And I presume in the Federal Civil Service you have many of the same things. I would certainly be surprised if you didn't.

What this all amounts to is a phase which we can call the seesaw phase. This is a period in which these disruptions and headaches and difficulties of the alcoholic employee pile up, pressing the supervisor to do something, but there also emerge numerous of these barriers to do something. And there is a seesaw.

Putting it in terms of one supervisor we worked with for a long time, "He pulls me both ways. There is a tug-of-war going on inside me, and I don't want to do anything."

So there is a seesaw phase.

All this time, of course, the alcoholic is getting worse, and all this time he is manipulating.

Then there really comes finally a phase which is a fairly long period of time from the early recognition that alcohol was the problem, which we can call the "decision to recognize" stage. And we can put a lot of detail in this if you want to. But there grow a series of on-the-job signs and symptoms along with increased job impairment and job difficulties, in which the supervisor finally says, "This person is different. He is abnormal. I will call him an alcoholic."

And these phases I think retard early recognition. And this is one of the reasons I said earlier that I don't like to talk about "early recognition." I doubt that there is such an animal.

I think we can conclude very quickly by saying that if you think the alcoholic and his wife have problems, then I can assure you that the alcoholic and his supervisor and his shop steward or his union representative have problems.

And I believe that, to go back to the points I made in the beginning, if organizations such as the Federal and State governments can formulate realistic policies that set the stage for supporting the supervisor in earlier recognition, in realistic con-

frontation and referral, that we can clearly produce reasonable results.

There are no panaceas, by any means. At the same time, as we look at the results of work-based programs in which the alcoholic is still intact, we are struck by the fact that here results are being achieved that are relatively impressive. And there is every reason to believe that, as we learn more about how to match therapy with personality and with social conditions, the results will be even better.

If, however, we wait until the situation grows so bad that the individual is apt to be hospitalized, then our chances have gone way down.

And certainly if we delay until the late stages, we have very little opportunity of doing much of anything.

A PARTICIPANT. I would like to say I did have one question when I came here, but you have answered it for me. That is, I could never understand how alcoholics lasted so long in industry. Why didn't someone just say to them, "You're not functioning; you have got to do better or go"? And this is just what you have explained.

Professor TRICE. There is a phenomenon which we sociologists call the normalization function. It happens in work groups. We normalize deviant behavior for a variety of reasons.

One of the most prominent reasons is that it occurs among persons with whom we have emotional bonds, in primary groups, and this is what happens in many work groups.

Or you can put it on another basis—a "keep it among the boys" kind of thing.

And we normalize these things rather frequently.

Many studies of deviant behavior consistently show that until those individuals that immediately surround the alcoholic are ready to see him as different, then treatment personnel rarely even get hold of him at all.

Studies of how people get to a psychiatrist's office show this over and over—that the psychiatrist is somewhat handicapped by the fact that he cannot reach into the family or work group and get the individual out of the network for earlier treatment.

We have clearly found that training will speed this up, provided it has two characteristics:

First, that it's training which is realistic in terms of the real

headaches that the alcoholic employee produces, because that will create social distance between the supervisor and the individual and he is willing to take action.

I think when we talk in fantasy terms about early recognition, we are deluding ourselves. But we can talk about "earlier" recognition at a time when he will respond to therapy.

We have a good number of studies which clearly show that the alcoholic has to be pretty well into alcoholism before he responds.

If you get him in those real early stages, he is not going to respond. There are too many reward systems operating.

The second point is if this training of supervisors refers to problem employees and you use problem employees as a way to train supervisors about general supervision, then it has a saliency for them.

We have been in this situation over and over. We have had a bunch of supervisors come in, and talked to them about alcoholism. You ought to hear the hearing aids go off. Some first-class resistances come up.

Then we attempted it in the area of the problem employee. What we did was take a series of psychiatric definitions of behavior and turn them into specific kinds of behavior on the job and use them as cases.

That produced far less resistance and more change, more response to the training.

Then we stumbled upon something serendipitously—namely, that if we use these problem employee cases as a way to talk about general supervision, every supervisor is worried about filling his role.

"How do I get to be a good supervisor? I want to do a good job of it." And it's a fairly difficult role.

So then we turn these things into examples of how you go about being a good supervisor.

In other words, the way to put the process of supervision into bold relief is: How do you handle the problem employee? And you put a couple of alcoholism cases in there along with four or five others, and they will learn a lot about alcoholism.

However, if you set them down for 10 to 15 weeks and say, "We're going to train you in alcoholism," it's certainly our experience, and our data indicates, that you are just going to be creating more problems than you are going to resolve.

You see, that is again the problem of parochialism in this area, the problem of focusing only on alcohol, which I think is very unfortunate, and this gets back again to the fact that you are talking here about occupational health in many dimensions.

A PARTICIPANT. Specifically, what would you recommend the policy be for the problem worker?

Professor TRICE. Well, I think, number one, there are a series of these phenomena. If you want to take alcoholism as an example, I think, first, large-scale organizations need to clearly state they are health problems, they are behavioral health problems. You see, if you study the reaction of the general public to the notion of mental illness, you get some rather strange reaction.

I mean I hear a lot of people rather in fantasy terms say, "We've changed the conception." We have a little bit—but not much.

And certainly as far as alcoholism is concerned, we haven't convinced the general public the alcoholic is sick. There are two very good studies to show that.

But I think the point is this: That large organizations set up a policy saying, "Look, this individual suffers from"—whatever phrase you want to use—"a behavior disorder, an illness"—But he suffers.

I have worked with a lot of alcoholics when they were having real fun. And I don't want to imply that that's not in the picture. When I first encountered this phenomenon I guess about 20 years ago at the University of Wisconsin, I got very intrigued with the questions of what is loss of control among alcoholics. So I followed a bunch of them around. We, believe it or not, spent $1,000 drinking with them. So we saw them in their native habitats. And I can assure you that developing alcoholism in some of its stages is not all the misery the official line claims that it is.

But let me assure you, at certain stages when the alcoholic comes out of it he is in real misery. So it is a disorder, malady, illness, whatever phrase fits the organization.

The second point is that you are going to include it under the same kind of constructive rehabilitation support. I don't know what your fringe benefits are here, but you are going to treat it the same way. You are going to do something. Thirdly, and I

think this covers more than alcoholism, you are going to encourage in every conceivable way a realistic confrontation.

I have used the word "constructive coercion" on some occasions. I think perhaps the better word is "realistic confrontation."

Of course, there is a whole field in social psychiatry called the utilization of the crisis, and that is what I really am talking about here. Instead of utilizing the natural crisis for mental health purposes, the use of what Alcoholics Anonymous calls "hitting the bottom" is I think realistic.

Some companies get that in by stating in simple terms: "After a series of realistic confrontations by the supervisor based on work performance, the company will consider specific kinds of coercive measures."

What happens is that a crisis—a clear-cut choice—is presented to the alcoholic. He is given to understand that he must "shape up or ship out" or, more to the point, that he must seek treatment or his job will be endangered.

Dr. SIEGEL. My question bears on the same area of realistic confrontation. How can the medical department of organizations encourage, assist, or influence managements of these organizations to promote constructive confrontation?

Professor TRICE. This can be accomplished by stimulating that kind of realistic training which doesn't focus exclusively on alcoholism or problem employees but uses problem employees as an example for good supervision, how to be a supervisor, and participating in that training itself if you can.

We discovered in two large companies that the nurse had more impact in training situations about many of these matters than anybody else. That includes the training director, the doctor.

We began to study this a little bit. What it boils down to is the nurse still carried a medical kind of halo and authority about her, that she has much less social distance than does the doctor. She is accepted, and many times she is turned to. So often, she is the key to training.

There are certainly other approaches to this. One is that you can educate line supervision when you deal with cases like this and get them at a later point. The doctor attempts in dealing with line management people: "Look, Joe, if you could just have worked with us earlier. How can you work with us earlier?"

Another is to study the basic problem of line-staff relationships in general. How do you reduce resistance of line people to staff participation? Get to know line people as much as you can.

Any organization has tremendous conflicts between line and staff. It's just built into organizational life. Get to know line people as much as you can, interacting with them in a variety of ways. Then when this one instance comes up, you have a chance perhaps for educating them, and they will turn to you quicker.

I suggest using the nurse sometimes to bridge the gap. Once this is accomplished the doctor is less formidable.

A PARTICIPANT. You tell us that we need to think in terms of work performance, crisis precipitation, and early recognition. We medical people think this is what people expect from us, and this isn't really our job—management.

When the alcoholic comes to the health unit, we are thinking in terms of what can we do medically. This person who comes says, "Now, you say I'm sick. Go tell management." And then this person becomes a cripple.

This I think is the reason for the confusion on what is our job for these alcoholics.

Professor TRICE. Certainly I don't assume any of those first points are your job. That's line management's position.

The PARTICIPANT. We don't either, but sometimes I think management feels, "What are you going to do about this?"

Professor TRICE. I think it certainly can be your role to participate in communicating and educating management to this.

The supervisor of an alcoholic goes through many of the denial processes the alcoholic goes through. And he has many of these vacillations. But if he will turn to anybody, in our experience, he'll turn to his own peers. He won't go upstairs about it many times. It puts him in a bad light.

You have a unique opportunity to educate him, because if you have any absenteeism rules, regulations, et cetera, you may be getting to this guy more frequently, and he may actually turn to somebody. He is going to start trying to turn to somebody. And to us the most unthreatening person that has some kind of knowledge is the industrial nurse.

Second is the question of referral. I think your ability and

knowledge of referral to AA or to community resources is very valuable.

A PARTICIPANT. Don't you think if these supervisors could be made to realize that they really aren't being kind when these people have a problem—they would get them, early, if possible, and not let them keep on going and not performing.

Professor TRICE. Many of these guys will listen to what you have just said. They won't listen to me at all. They deal with you. If you said what you just now said to such persons on certain occasions, you could have some impact on them.

Training can have an impact on them too—and does. You can speed up this recognition process I describe.

We have had industrial nurses come in and say just this sort of thing to management, and they will listen, and they will change. We can't get them to change. We get a bunch of them down around a table, and the rejection is quite high.

If we get another supervisor who has been through it to act as the conference leader and discuss it with them, then we get changes, and we talk about the extent to which this represents the way to be a good supervisor. You learn how to be a supervisor through working with the alcoholic employee or the problem employee.

So what I am saying is that you can do just what you have just now done in your organization and have quite an impact.

Dr. PHILLIPSON. Would you care to say anything at all as to how management might work a bit more with unions to hasten the crisis precipitation?

Professor TRICE. This is the greatest stumbling block in the work world. The first step is to keep the union fully informed.

I am quite distressed over a series of developments in companies and State governments in which the union has been left out or told later. The union has three reactions. The first is, "We have to protect this guy." The second is "He paid his dues, and if he is confronted this way and management knew it, we are going to walk the last mile with him." And the third reaction, which is sometimes the most constructive, is that, "We are just going to sit back and wait and see, and maybe we will support you and maybe we won't."

Well, if you people do anything in the Federal Government, get the union involved, aware of what you are doing, represented,

with some degree of consensus. Change your policy if necessary. The upcoming field in unions today is in governmental service, both Federal, State and municipal. You can stumble all over yourself on policy like this if you don't include them and if you don't do it in a realistic way. They can be very potent.

If you have a shop steward and a foreman confronting realistically at the same time along with somebody in the family and circle of friends you have a chance, a real chance.

Recognizing the Alcoholic

Richard Phillipson, M.D.

(A psychiatrist, Dr. Phillipson is Visiting Scientist with the National Center for the Prevention and Control of Alcoholism, NIMH. He is a British subject, and for many years served in the British Army and Civil Service.)

Dr. Weiland did cover in a large measure the question of the recognition of the alcoholic, the detection of him. And that's just as well, because I haven't a tremendous amount of personal experience to give you on this, for the very simple reason that this whole question of the recognition of the alcoholic within the Civil Service is a field that I've only become acquainted with to any great degree in the last 6 months in this country.

Previous to that I did have 8 years at the Ministry of Health in London, but we were doing little or nothing about recognizing the employees' drinking problem.

Prior to that, I had 26 years in the British Army, and my last post was Chief of Army Psychiatry.

In the British Army the psychiatrist looked after alcoholics in the army, the navy, and the air force, so we did have a little experience with this challenging health problem.

I will tell you a little more about that, because I think it is possibly of interest though different from the problem that is facing you now.

How are we different? Of course, we are very different because we are such a closed environment, a closed community. If the soldier is not on parade when he should be on parade, the sergeant-major knows about it very quickly, and before long that soldier knows that the sergeant-major knows.

And similarly, if the officer is not on the job, his commanding officer knows pretty quickly, and he knows the reason why.

In most areas in the British Armed Services, especially overseas at any rate, you can buy liquor from the army. You pay for it monthly in arrears when you pay your monthly messing

and mess account. And in various areas it is not possible to buy alcohol anywhere but from the equivalent of the PX.

So, naturally, your consumption of alcohol is known by the size of your mess bill. And this is another very small point. But alcoholics as a whole in the army come to light much more readily.

There are other reasons why they come to light that are more applicable to your situation. When dealing with male alcoholics, change in work performance, absenteeism, and attitude are indications to the supervisor or fellow worker that all is not well with an employee. But who is the first person who knows really, even before the supervisor or even before his fellow workers? I think the first person who knows about the male alcoholic is his spouse. Of course she knows. But how is she going to let you know?

In the British Army this was very simple. For example, when I was the commanding officer of various hospitals, my wife had a part to play. She was ex officio, as the wife of the commanding officer, the chairwoman—or the chairman—of the wives' club. And the wives' club met every week regularly as a routine, one morning a week, with various activities.

There was the "well baby" clinic. All the mothers who had babies brought them to be weighed. And my wife and the district nurse, or whoever it was, took part in the solemn process of weighing the well baby. And then they got down to the coffee and the buns and the "natter"—what we men used to refer to as the "nappy natter." And this is where, quite frequently, the news came out that Mrs. Brown was very worried because her husband was drinking too much or had some other health problem.

I mustn't deal too much with the British Army because as days go by it is shrinking, and being smaller it was very much easier to run, in certain ways, than is your Army.

Early in November last year I went to consult at an Army camp where one reasonably-sized special program for the treatment of Army alcoholics is in progress and has been for some 2 years. It is run by a very active young physician. He scheduled an afternoon meeting with all the line commanding officers, and colonels and brigadiers of this very large training base. We also got quite a few of the staff officers, including the chief of staff. The general commanding the base was represented by his chief

of staff, and we had a very good discussion for the whole of the afternoon, on what to do about the soldier with this health problem.

I don't want to belabor the point, but an important consideration in all three U.S. armed services is that alcoholism is not considered an illness. Alcoholism per se is not in the line of duty; that is, it is a self-inflicted injury, and if the soldier is diagnosed as an alcoholic he is almost certain to get a dishonorable discharge and to lose all pension benefits.

Now, this is a very awkward matter and leads to a lot of maneuvering similar to what had been going on in other work settings. Should you be diagnosed as having cirrhosis of the liver, gastritis, or peripheral neuritis, you are normally given an honorable discharge and receive all the pension benefits to which you are entitled. So, as I said, this leads to a lot of maneuvering.

One of the commanding officers got up and asked, "Could you tell me what I do with a sergeant who is on parade every morning at 5:30 and works right through the day drilling the men? It's a very big training base; they are drilling throughout the day and training in many other ways. He works right up to the last minute he should but I know from my wife who knows from his wife or from other wives in the wives' club, because they have the same situation, that within an hour of getting home he has gone through at least a bottle and possibly two bottles—that is, two fifths—of bourbon, and within 3 hours he is 'out of this world.' He's impossible to live with and he just wakes up in time to get on duty. How do I deal with that? Because as far as I'm concerned he's a first-class sergeant."

I replied, "Surely, the Army works by night as well as by day. And surely if you have night exercises often enough this man won't be available."

And to my amazement he said, "Oh, but that wouldn't be fair, would it?" In other words, here was a very senior supervisor who was putting up just the same resistance that many supervisors do.

I referred briefly during Dr. Weiland's talk to this question of training of supervisors which is already taking place in Albany, N.Y. This is being carried out by the Civil Service Commission, but the Department of Mental Health plays a part in

this training. I went up there and sat in on one of these training sessions.

Most of the class were men. There were one or two ladies. I'm pretty certain there wasn't one volunteer among them. They appeared to be not overly impressed with some very good instruction. Questions were slow.

But near the end of the last session—and this is frequently a point where you get the very best, just at the last minute, when half the people want to leave because you have already overrun your time—a young man got up, very big, well-built, somewhat red of face—it might have been due to the sun, might have been due to other things—and he said, "You've been talking about early signs of alcoholism. How do I know when one of the men that I am supervising is becoming an alcoholic?" This rather surprised the man who was giving the talk, and he turned to me and said, "Doctor, would you mind taking this question?"

And I was very glad I did, because I gave a very quick rundown on the blackout and gave them a picture of a man who has been out drinking, a heavy drinker, who wakes up one morning and hasn't any memory of the night before at all. He has no conception of where he was the night before.

And then he has a glimmer of an idea that perhaps he was out in his car. Then he suddenly says to himself, "My God, I wonder if the car is in the garage?"

He manages to stagger out of bed, although he has a frightful hangover, and he crawls downstairs, looks in the garage, and is happy to see the car there.

And I repeated, "He still has and never will have any memory of how he got home."

Then I said, "Ladies and gentlemen, this to me," (Don't forget these were supervisors, so I went into detail that I wouldn't need to do with you) "This is a very good example of a warning sign that that man should quit drinking, and if he's going to start again ever, it should be in the long distant future when he knows better how to handle alcohol."

To my absolute amazement, this man replied, "But, doctor, surely everybody who drinks experiences that."

In other words, he was possibly having blackouts but he didn't realize at all that this was in any way an early sign of dependence on alcohol.

Questions and comments like this sometimes suggest personal involvement, but one must not jump to conclusions.

Well, this is wandering in a certain way from the real essence of what I should be talking about—how to recognize the alcoholic.

First, a definition of alcoholism. The subcommittee on Alcoholism of the World Health Organization defines the condition as covering "those excessive drinkers whose dependence on alcoholism has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and social and economic functioning"—and the last is most important—"or who show the prodromal signs of such development."

Now, I believe this is the important thing. What are the prodromal signs of the development of all of these symptoms—the mental disturbance, interference with bodily and social and economic functioning.

Like all definitions, of course, the WHO never went on to describe what were the prodromal signs of such development. But there are readings that are of assistance in this.

One I would recommend is "Problems in Addiction" which is one of a series of books by the Fordham University Press, the Pastoral Psychology Series No. 2, edited by William C. Bier. This, in my opinion, is worth looking at because it does bring out to a certain extent the early signs of problem drinking.

These early signs were very interesting to me, because I think we may be making a mistake here in concentrating so much on the problem of alcoholism and so little on the problem of intoxication, particularly when we are talking to young people, in just the same way as we in Britain may have been making a mistake in the past decade in talking so much about the dangers of smoking and lung cancer and so little about the dangers of smoking and bronchitis.

We know that 3 to 6 percent of those who drink are likely to become alcoholic. But how many of those other 94 to 97 percent are likely to become intoxicated, and when intoxicated, although anything but alcoholics, are likely to get into the most frightful trouble on the roads and elsewhere?

I feel sure that there is much more reward to come from instruction to the young about the dangers of intoxication than about

the dangers of alcoholism, which we all agree still occurs in the late 30's, the 40's, and 50's.

But it is not only the young who need to be taught about the dangers of intoxication. I see you are able to obtain a driver's license in some States at the age of 14, whereas in Britain you are not allowed to drive a motorcar until you are 16.

But we in Britain do allow you to drink when you are 16 also, whereas in certain States you don't allow your young to drink until they are aged 21. So you are more permissive with driving, but you are much more restrictive with drinking. And, of course, we all know that the young drink in many, many situations long before the permitted age.

At another meeting 2 weeks ago, a doctor from Lansing, Mich., spoke of a program for alcoholism that he was running. He developed liaison with the judges in the local courts, so that a new procedure was developed for handing any young man brought before the court on a charge of drunken driving. This charge was put in abeyance for 2 months. Once a week for the intervening 8 weeks the young man attended a compulsory series of lectures by this doctor and his staff on the problem of intoxication and driving.

I won't say he goes through an exact examination at the end of the eight sessions that he visits—and he pays $5 for each session—but if he doesn't get a good report on his attendance, when he appears before the judge to have his case heard, he's much more likely to get a more severe sentence for his drunken driving than he is if he has a good attendance record and gets a good report.

This to me is a very good attempt at prevention.

Now, how do we deal with this question of recognition of the alcoholic? Quite frankly, I don't really know but the experience developed by the employers in the private sector suggest several examples that can be useful to Civil Service employers and employees.

Programs are being developed for Civil Service employees in two States, New York and Pennsylvania. Experience coming from these relatively new programs indicates that supervisors are playing a major role and that some employees with drinking problems are seeking health services voluntarily. Much depends on how

well the environment has changed so that drinking problems are accepted as are other physical and mental health problems.

I take the point from Professor Trice that in the case of industry it's very much easier because industry has got together with the sociologists and others who can be of such tremendous help in furnishing the hard data that are required. They have recognized the problem, and they are working with it.

And, happily, the unions are starting to work more closely with top management also and there is no reason why these kinds of relationships cannot be developed by the Federal Civil Service.

As I mentioned to Professor Trice after his talk, I was in New York City discussing this question with a person who is a senior management consultant there on alcoholism in industry. This man said to me, "I'm getting somewhere with the unions as well as with management; they are beginning to understand the concept 'Don't let Charley die'." He manages to persuade unions and management, as well as supervisors, that they all have a duty to keep Charley alive no matter what his illness.

This is a possible way, as Professor Trice so rightly put it, that you ladies who are nurses can get together much more readily than we doctors—and especially we psychiatrists—with the supervisors and the shop stewards. They are unlikely to be suspicious of nurses, the same is not true of other health professionals. They are likely to listen to you, and I would hope that this would be another fruitful way of getting early recognition of the employee with the drinking problem.

I would like to run down very briefly, if I might, the indicators mentioned in the "Key Step," because I have given you very few indicators. Many of them have been referred to already, but I would like to expand on one or two of them if I may.

1. The first one is repeated Friday, Monday, or halfday absences. Well, that's an easy one.
2. Secondly, frequent reporting of absences by members of the employee's family or persons other than the employee himself. He doesn't report in, but his family get anxious, and they report in.
3. Unusual excuses for absence.
4. Lying about inconsequential matters.
5. Display of an increasing lack of responsibility.

6. Mood changes in a previously stable employee. Fairly similar to the developing anxiety state that one found in the soldier over-exposed to stress in the front lines.
7. Frequent loud talking or irritability. This is frequently in my experience covered up at work especially within the hearing of the supervisor.
8. Avoidance of the supervisor.
9. Long lunch periods.
10. Frequent use of breath purifiers. I am not too happy about this one because it could be used for so many other quite reasonable complaints or problems.
11. Hand tremors, flushed face, or other commonly recognized physical signs. Again this one could be due to alcohol but could be due to other things.

One would hate to say to a person who isn't an alcoholic, because he has a red face or because he is using a breath purifier, "Do you have a drinking problem?" Redness of the face appears in many other unrelated conditions and although I'm not going to go so far as to say I would rather miss an alcoholic than do this, I would very much regret having accused or suggested to somebody that he had a drinking problem when all he had was some other personal problem about which he was very self-conscious.

The one thing I would like to know is: Is there a lot of absenteeism? Are there more accidents that are causing physical illnesses, broken bones, and all the rest of it, that are being missed by us professionals? Data like this have been developed by the employers in the private sector and it could be that similar approaches could be made within the Civil Service.

I am sure that I have talked enough. If I can answer any questions on the basis of my previous 8 years experience in addiction units in Britain, or the very much briefer but in many ways more stimulating experience I have had in your country in the last 6 months with the National Center, I will be happy to do so.

Dr. SIEGEL. Doctor, you struck something that we have all faced up to, and this is the problem you mention in the Army, it's true at least by the letter of the law under Civil Service that inability to perform duty because of alcoholism pure and simple is a line of duty "no-no." It's malfeasance rather than due to

illness. So a good deal of maneuvering has to be done to get around this.

Are there any experiences you would like to relate or comments as to how to do the best maneuvering and what is the medical department's role as long as such maneuvering has to be done?

Dr. PHILLIPSON. First of all, within the British Army, as Chief of Army Psychiatry, I was able to get alterations in certain policies very readily. The way I dealt with the alcoholic—and when I say dealt, I mean the way I got all psychiatrists in the British Army to deal with it, with the approval of the staff and the Surgeon General was this:

A soldier or an officer sent to us because of a drinking problem was admitted to the hospital, was offered treatment if he wanted it (group therapy, individual psychotherapy, Antabuse if he was suitable and wanted it), all the various physical and psychiatric methods of treatment that were available.

Upon completion of his treatment, he had adequate followup treatment within the unit to which he went. And he didn't necessarily go back to the same unit from whence he came.

This is a very important point because quite frequently the immediately precipitating factor may be within the unit, or, at any rate, his problem is so well known within the unit that he ought to be given a fresh start.

On completion of treatment he was told that if he relapsed he could come back again, and could have a second chance, but if he relapsed once again, I used what I call the "third offender's act." I don't know if you have the same legal term, but for any crime, especially of the young in Britain there is the first offender's act by which you are almost certainly going to be what we call "let off with a caution."

But I implemented what I called the "third offender's act"—that if a man relapsed a second time, unless there was a very good reason for him to be separated medically, he was available for separation administratively.

This didn't imply the rigid dishonorable discharge that you have in your services, but it did imply that if he didn't have pensionable service, he didn't get a pension.

Pensionable service with us in those days was 22 years. And the bulk of our soldiers and officers who got into trouble with alcohol eventually were separated almost invariably with between

16 and 18 years of service. It was what we call the "drunken major syndrome," because the officers were nearly all majors, and a majority of the other ranks, the soldiers, were company sergeant-majors. Some of them were sergeants, but they generally made, by 16 years of service, company sergeant-major. So, as the majority of this problem group were in the major or company sergeant-major rank, it became known as the "drunken major syndrome." And the funny thing is that it's exactly the same in your Army.

With us, the man with 15 to 17 years of service had not earned a pension. He had to do 22 years. If he got a medical discharge, he got a modified pension. A lot depended on what the man's outfit said to us. If they said, "No, this man had really been a very poor soldier and he has committed a lot of minor and even major offenses, including monetary offenses"—he was separated administratively and didn't get a pension. You may say this is hard, and it was very hard, especially on the dependents.

But where I had a frightful conflict of conscience was that if I separated him medically, he got a pension—and what happens with a man in his middle 30's to whom you give a pension as an alcoholic? Is he going to be alive 5 years later?

Certainly my experience down in Alabama, last week, with the moonshine souped up with chlorox is indicative. If you give a man down there a pension of $2,000 a year and he buys a little farm and makes moonshine and somebody else "soups it up" with chlorox for him, he is not going to live 3 years, much less 5.

So are you right in being kind—in giving him the benefit of the doubt and separating him medically, and giving him a pension?

If he doesn't have a pension, he is going to have to work. If he has to work, he is going to live longer. There are two things you need for continued alcoholism. One is the susceptibility to alcohol, and the other is the availability of alcohol.

Even in your country, where it's a third the price it is in mine, you still have to have a certain number of dollars to buy alcohol, and if you haven't got that money coming in regularly and have to work for it, you may live longer.

Professor TRICE. I'm very much intrigued, Doctor, by your point that you would not give this pension, because I think it underscores what to me is vital. And that is that in the final

analysis there has to be some sort of realistic confrontation that is carried through, some sort of "constructive coercion." Some people think it's too strong. But it seems to me you are saying the same thing.

I have been in companies who faced the same dilemma: Shall we really now follow through completely? And some of them have hired this person later after they did follow through completely. But they were forced to follow through, even though there was a mild risk of suicide, a slightly higher risk of suicide, though not too much.

Dr. PHILLIPSON. I should add here, please don't think alcoholism per se is attributable to military service. A lot of people would like this to be so.

Professor TRICE. We discovered that the military service didn't have much higher rates than other occupational groups, from what little data we could get. And it was the same point. After 17 or 20 years of service, and at certain occupational levels where the guys had gotten stuck—the "major syndrome," the assistant manager level in a large grocery chain—that seems to be where it was lodging.

Dr. PHILLIPSON. Yes. And strangely enough, the one program in industry in civil life that we got off the ground a few years ago in Britain was in the equivalent of your PX, what we call the "NAFFI," the Navy, Army, and Air Force Institute, which sells canteen supplies to the soldiers both at home and overseas.

At home it is not much of a problem, but overseas this is an entirely civil organization within the military setup, and alcoholism within the civilian-staffed military canteens overseas is a tremendous problem, one of the reasons being, of course, that alcohol is so very much cheaper.

If I can dwell for just 30 seconds on this, to give you an idea of how "you've never had it so good" here as compared to Britain, a bottle of scotch in Britain now is about $8 to $9. Overseas with the soldiers it's about 80 cents. And when you say to the soldier "You know, you have really got to cut it down," he says, "Doctor, please sir, I can't afford not to drink—80 cents compared to $8."

This was the best British scotch which was exported to them. If they bought the local stuff, of course, it was half again as cheap, but possibly not quite so pure.

And there was another question too. When a patient does come to you and says, "All right, I have got a problem, and what are you going to do about it?" do you have to preach total abstinence?

I wonder. If you do, he is almost certainly not going to come back to you straightaway.

You do preach, in my philosophy, total abstinence as far as possible, but you do admit that this can be to a certain degree a chronic relapsing disorder and that if he does relapse, you will still be there and you will still take him back again.

I thought of that when you brought up that first point about these people making you feel so helpless because there is so little you can do for them. Well, there may be very little you can do for them, but you musn't let it get you down, because even doing a little for them sometimes does result in quite a lot coming out of it.

The Point of View of the Recovered Alcoholic

Will B. and Jan S.

(Will B. and Jan S. are members of Alcoholics Anonymous. George C., who speaks from the audience, is a third member of AA, who accompanied them.)

My name is Will B., and I am an alcoholic.

I came to Washington nearly 20 years ago because my sister was in trouble with alcohol. I am happy to say that today she is all right. She's now living in San Antonio and reunited with her son and grandchildren.

She had an interval of sobriety. Then she went overseas, and took the AA program to Okinawa. She returned, and things weren't going her way, so she said, "To hell with it all," and started to drink again.

And in her second interval of alcoholic drinking, she nearly died and had nurses around the clock.

But she did stop, and she's all right.

Some 15 years later I was in trouble with alcohol—I who had said I would never become an alcoholic, that I would never drink unless I drank in a nice place, that I would never drink unless I had the right glass.

But I passed over that invisible line from social drinking, whatever that is, to alcoholic drinking, which eventually meant to me that I drank a fifth each night.

Now, I could rationalize this because I had a heart condition, and when I had angina pains I knew that a shot glass of bourbon would ease those pains—and more pleasantly than nitroglycerin.

But it got to a point where all night long I kept getting out of bed for one more shot glass of bourbon. And I did not keep the liquor near me. I kept it so I had to get up and walk to the kitchen. Eventually I was drinking a fifth a night, and later on I was drinking another fifth during the day.

I knew I was an alcoholic long before I decided to do anything about it. In fact, I had read the original "Saturday Eve-

ning Post" article by Jack Alexander that gave the first national publicity to what AA was doing.

And I had no intention of stopping drinking, because I really was having a good time. If you think you're having a good time, then you are.

But there came a point—and the late Dr. Theibout, in making a reference to "bottoms," says that a bottom can be any place the alcoholic decides that he's had enough. Well, I called AA headquarters one time and asked for the nearest meeting.

And I went to the nearest meeting. But I fooled around with AA for 10 months, or, as somebody put it, I was an "outpatient of AA."

But at the end of 10 months I moved, because I had to take care of my sister who had become diabetic, who had a condition that the hospital called tightening of the arteries, and was no longer able to work. And I moved 4 years ago, on April 1st.

As usual, I called the liquor store and I asked them to send over a fifth. And on April 1, I drank half that fifth, and on April 2, I drank the other half. And that has been my last drink to this moment.

Somewhere in there I decided I had had enough. And I embraced the principles of AA.

Here I will stop and tell you what Alcoholics Anonymous is.

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership. We are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organization, or institution, does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

As part of helping the other alcoholics, my next speaker, an associate who is in the audience, and I man the desk at headquarters. And the queries that come in are, you know: "Where is there a meeting? What can I do about my alcoholic husband? What can I do about my father, my mother?" Some of them are utterly ridiculous. And I have learned that history repeats itself.

About 3 years ago I had a call, and I said, "Decatur 2-1933, may I help you?" And a woman's voice said, "Yes." Then she said, "You sound happy." I said, "I wouldn't say I'm happy, but I'm content."

And we talked for a few minutes. And she said, "You sound young and vibrant, why don't you come over and explain the AA program to me?" I said, "Well, I'm not that young, and I lost all my vibrancy at the end of World War II and the years I spent in New York drinking."

Then we settled for a more orthodox way. I would get in touch with a woman in her community to make what is known as a "12th step call."

About 3 weeks ago, I answered the telephone. I said, "Decatur 2-1933, may I help you?" And a woman said, "Yes, I hope you can." We talked along for a few minutes, and she said, "You sound young." And I said, "But I'm not that young. I was in World War II."

So then we talked along. She wanted to know my profession. And I am a writer, and I am a conservationist, and I was born in upstate New York. She said "Tell me why are so many writers alcoholics?" And I said, "Well, I honestly don't know." And she cited Edgar Allen Poe, may he rest in peace. And I went on to talk about the man who wrote "The Edge of the Volcano," Malcolm Lowery, and others over whom alcohol had triumphed.

She said, "Well, look at their contributions." And I said, "Well, yes, but perhaps if they hadn't drunk alcoholically, they would have made even greater contributions." "Well," she said, "I'm a writer too. And if I thought I could leave any sort of literary heritage, I'd go right on drinking."

I said, "You know lady, that's your privilege." Then she said, "What's your religion?" And I said, "I'm an Episcopalian." She said, "Tell me, why are so many Episcopalians alcoholics?"

Well, this is, you know, part of the game. I had no answer. Writers don't have a corner on alcoholism. Episcopalians, free-wheeling as we are, don't have a corner on the disease, if you want to call it a disease, which I think is listed as fourth on the list of killers.

There is a little squib I cut out of "Today's Health" of last month. It says: "About one in every eight beginning drinkers eventually will suffer from alcoholism, according to the National

Institute of Mental Health. There are an estimated 6.5 million alcoholics in the United States today." I don't know whether that 6.5 million includes those of us who belong to AA. A rough estimate of our membership is about 400,000.

AA works apparently well for some of us. There seems to be a percentage who never get the program. A man that Jan and George and I know was found dead a week ago down in Orange, Va.

Now, perhaps he was one of those people that have a deep-seated emotional problem. Maybe alcoholism was only a symptom of something that bugged him to the point where he went out and drank again. That I don't know.

Anything I say is only Will B. speaking and his reaction to the program. I do know a great many alcoholics are arrogant, and I do know that I was. I wrote three extremely successful books. One was a selection of the Outdoor Life Book Club. Another was on display at the Palais Wilson in Geneva as an example of good bookmaking. And the third was used in a seminar on East/West cultural relations in New Zealand.

I got stranded in Montana once, when I was on a field trip, and I didn't have any money. I wrote to my publisher for money and he sent it to me. I was also once introduced at a Washington Booksellers Association dinner as "Washington's own Will B."

Now, this sort of thing really can do a lot for your ego, and perhaps you really become arrogant, and you have to lose this arrogance and self-centeredness and a number of other qualities—described as a conversion process—before you really can stop drinking happily and become content and live the so-called normal life with your associations in the workday and social world.

I lost the compulsion to drink. I rarely think about drinking anymore. Sunday I was asked to dinner for Easter, and for my birthday, and my hostess said "wouldn't I have a sherry?" And I said no. And then we went to dinner, and it was "wouldn't I have a drink?" And I said no. And wouldn't I have a liqueur. And I said no. It doesn't bother me to say no, because it's really no one's business why I no longer drink. I am a person that has freedom of choice. And I always can drink if I should be foolish enough to go out and take that first drink. For my own thinking, if I ever drink again, I will never make it back.

I used to say I was never hospitalized for drinking. But in retrospect I know I was, because I awoke one morning with a pulse of 200—and that's an awful lot of pulse—and I was sent to Georgetown University Hospital as an emergency case. Then 2 months later I had a variation of this pulse business.

And at a doctors' and dentists' retreat, to which my doctor always invites me, I had a coronary in bed and was brought up to Georgetown University Hospital. Now, I realize that all three of these heart attacks or variations or accelerated pulses were due to lots of drinking, lack of sleep, and little food.

Of course, since then I have had two more variations of a heart flareup and was also walking around with double pneumonia.

I once called for the Rector of my church, and subsequently I got Father William A. Wendt from St. Stephen's and the Incarnation, and, to make it very brief, I said to him, after I had talked a while, "I don't know why I'm not dead, Father." And he looked at me and he said, "Will, you're not dead because you're not supposed to be dead."

In other words, I guess I'm supposed to go on writing, and, within the limits of not very good health and with Meniere's Syndrome, try to help other alcoholics.

Now, I would like to introduce a woman I admire enormously; one who can present you the woman's view of what it means to drink alcoholically. And then we will be happy to answer any questions you have about AA.

Jan.

JAN. My name is Jan, and I'm an alcoholic. By the grace of God and AA, I am a recovering one. And I say "recovering," because I think our recovery is an on-going thing. I feel that there is always more for me to learn, and there is certainly plenty of learning available if I will grasp it.

I will qualify myself very briefly by saying I spent 21 years drinking to excess, because I liked to. And I would like to blame my parents, because it is very fashionable to blame your parents. But, terrible as I think they were, I think everything that occurred to me because of them was through love and through a sense of responsibility. I feel now that a standard was imposed upon me which I couldn't fit, and I think this probably had good intention behind it, but I could not conform to this standard. And so,

consequently, I always felt inferior and inadequate and in the wrong. So when I discovered booze at age 16, during Prohibition, by the way, it performed some kind of "magic" that made me no longer inadequate, inferior, in the wrong.

A certain amount of booze made me level with everybody else, and a certain amount more made me superior to everybody else. So why wouldn't I seek this?

I pursued it for about 21 years because I believed it did so much with its magic and I believed it so beneficial. I think now that my emotional growth was arrested at age 16 until the day I approached AA.

Needless to say, it went from bad to worse, and it took more to get the same effect. And I began to switch from pleasure drinking to dependency drinking, to needing drinking, needing liquor to keep going. And this is not any fun.

In the meantime I was gradually learning a few tricks to maintain my right to drink. I was learning to lie and cheat and connive and compromise my own interior code. So, with all, I was drinking prodigious amounts, far more than a lot of men I know. A lot of men that I used to drink with couldn't keep up with me. I could drink well over a fifth a day. And at the height of my best drinking and worst behavior, which were synonymous, I was drinking maybe two fifths a day, plus all the beer I needed to quench my thirst—but still functioning, driving a car, taking drunks home, doing things.

And during that period I married a playmate who was of the same persuasion, also alcoholic. And the only reason I married him was because he was the wildest man I knew, and everybody else I knew was pretty dull, pretty conventional.

I'm glad to say he's now in AA, too, but we're no longer married.

I came into AA in 1952 when all the self-loathing that was driving me came to the surface—over a very small thing. I was about to write a bad check to get another bottle. And this is very mediocre as a confrontation with self, because there have been some very startling awakenings in AA. Other people have had much worse things happen to them than that. But this focused it for me.

[illegible] glad now I called AA—without any real hope, [illegible]ve I was so different. But I found when I came

to AA that I fit some place in the middle. I wasn't the worst, and I wasn't the best.

Since then, using the simplicity of the AA program and the guidelines provided, I have learned how very, very sick I was. Maybe "condition" is the better word for it, because I do think "disease" implies that you can't help it. And there seems to be something volitional in alcoholism. Nobody can activate mine but me.

However, these are points for professionals and not for me. My alcoholism is a fact, not a theory, so I will deal with my facts.

I found that I was not only sick at the physical level but spiritually, emotionally, and mentally. I needed what I was receiving in AA. I had no realization that these needs were not met until they started being met.

I needed to belong. I needed to be in an environment where I was not judged. My own self-condemnation and judgment of myself was so harsh that I imputed it to other people.

But in AA the environment was quite different. It was an environment that sustained me, conveyed to me a belief in me as a person, and it was for me the great environment for recovering, for pursuing the search for authentic self-hood.

I think that all the energies of my past, in my drinking days were devoted to either apologizing for or defending the way I am programed. And I learned in AA there's nothing wrong with the way I am programed; that I'm not a nut, I'm not weak in character, I'm not morally deficient, that there isn't one thing wrong with being an alcoholic, that it does not impose any limits on me except the limits I voluntarily choose.

I used to think when I was new in AA that these people were very obsessive about this word "sobriety," but I have come to believe that maybe this is the word that trips people who are not alcoholic who try to help us, that "sober" has deteriorated in meaning to simply mean "nondrunk." AA has perhaps recaptured the old meaning—a quality of spirit which embraced wisdom, judgment, balance, and other virtues such as compassion, sensitivity to the needs of others, a response to those needs.

This is what sobriety has meant to me, to grow in this direction towards a relatedness to other people and relatedness to the world around me, that I have finally found something worth conforming to.

For a woman in particular to know herself to be a drunk is absolutely devastating. I think we are far more dishonest and far more skillful at lying and conning and far less apt to believe that we can be brought back, that we can be brought to a point of respecting ourselves or deserving the respect of others.

This is one of AA's miracles as far as I am concerned that the guidelines are provided in the program, that it is a very whole program from my point of view. It does assist me physically, mentally, spiritually, and emotionally towards growth. But it has to be at my pace, and it has to be through channels that I choose.

I have learned the channels through which my energies should flow so that they can be more effective. I have learned also that I am not a parasite, that I can be contributive, that I have some value.

Nobody could have gotten this across to me before, because I was so bound up with phony complexities.

However, nobody—but nobody—could have convinced me that I would ever have any fun without the bottle. But I have had more fun in a diversity of ways in the last 17 years in AA than I ever had in that thoughtless and superficial and frivolous pursuit that I indulged in before.

I think it is very difficult to get this across to an alcoholic. I think everything about the condition, disease, or whatever it is, contributes to keeping us blind to this being the problem. Everything else is the problem. Other people are the problem—the boss, the husband, the wife, the other anything—anything but "poor little me." I'm a "victim."

The fact that AA can penetrate this kind of self-delusion—because self-delusion in active alcoholism is pretty total—I think is a great miracle.

I think also it is a miracle that an alcoholic would be open for that split second of truth to reach for the telephone and call AA. I am so grateful that it happened to me, and for me, like many other AA's. I want to convey the message and do what I can to support others.

I think this is all I'm going to say now.

WILL. Thank you, Jan.

Jan mentioned one point—an alcoholic really has no one to blame but himself. This is not original with me. Granted that

alcoholic drinking makes you irresponsible. You may have some excuse to drink when you don't know what it does to you. But once you know what alcohol does to you, then in a sense, almost paradoxical, you have a responsibility never, never, never to drink again.

This sounds sort of tough. But once the practicing alcoholic knows that he shouldn't practice his disease, as somebody has said, then he should not drink again.

If any of you good people have some question that you would like to ask about AA or ask Jan or me or George sitting over there, how we stopped drinking, which is the great big question—and let me say here there are other ways to stop drinking than that we in AA have found. For us our way is the most successful.

A PARTICIPANT. Maybe I could start you off with one. We are going to, in our Federal employee health program, be looking for ways to relate to community resources and to refer people with drinking problems to community resources.

Obviously, one of the preeminent resources is Alcoholics Anonymous. It is my understanding at any rate that AA would be loath to pick up the telephone and hear somebody say, "Hey, we've got a fellow we're sending over to you."

Would you care to discuss ways in which we could perhaps relate to the AA program as far as referral is concerned?

WILL. Well, that little leaflet we brought down; "AA in Your Community," is helpful. We do get calls when we are told that they are sending somebody around and what can we do to help the individual in question? At 2627 Connecticut Avenue, which is the Washington Area Inter-Group Association quarters, we keep, of course, a file of all the groups in the area, and there are nearly a hundred in Greater Washington, and we keep a number of places for referrals.

Members of AA maintain the Metropolis Club at 921 12th Street, which is a place for people who are coming out of rehab programs to go. It is a place for recovering alcoholics to go. It is open from 10 to 10. There is always coffee there and somebody to talk to, and there are meetings throughout the day, and every night.

Members of AA also maintain a women's home, and this is for women with a similar problem of no place to go. And there

are a number of halfway houses, so-called, around town where the destitute alcoholic can be put up.

Through the rehab program at St. Elizabeths they are trying to set up a series of half-way houses where there is some supervision.

The man in charge of the alcohol and drug program at D.C. General tells me they hold patients 5 and 10 days longer than necessary because half the patients over there have no place to go when they are discharged.

I think this is something the Federal Government and the D.C. Government are working on to try and establish a series of halfway houses or rest homes or whatever you want to call them.

We also keep at headquarters a referral for Gamblers Anonymous, Narcotics Anonymous, the problem of suicide, which of course, can all be tied in with alcoholic drinking.

Of course, primarily Alcoholics Anonymous is to help the person who wants to stop drinking with his problem. It is a self-help program, as somebody mentioned. And AA cannot implant the desire to stop drinking. I know from my sister, because her husband wanted her to stop, her mother and father wanted her to stop, I wanted her to stop, but she did not stop until she was ready to stop or hit her so-called bottom.

Twenty-six twenty-seven Connecticut Avenue is open from 10 until 10, and we welcome your calls. And we can send you the local directory. We can send you literature. And we can refer you to New York.

There are Spanish and French editions of some AA literature.

There is also the Northern Virginia Group Association where you can call from 10 to 10. These places are all listed in the directory of the meetings around town. There are beginners' groups. There are women's groups. There are classes, there are steps. And there are open meetings.

GEORGE C. (from the floor). Well, the question I think the gentleman asked is about somebody sending somebody. By all means, we will talk to anybody you send up there if he comes up.

What we have resented is third-party calls about somebody else's drinking. We can't help anybody there. At the information desk, we deal with the rather unique alcoholic, one seeking help. And if anybody is sent there, somebody at the desk—in three-hour shifts from 10 to 10—will be very happy to talk to the person

and try to relate to him or put him in contact with somebody who can relate to him.

The only thing we object to, as I said before, is a third party calling about someone else's drinking.

But if a person comes up to the desk or we can talk to a person by phone—if they are willing to get on the phone and talk to somebody on the desk, we can help them.

WILL. I walked into 2627 Connecticut Avenue the other day and somebody introduced me to Joe. And Joe said, "I know Will. I came in and talked to him about AA 3 years ago, and I haven't had a drink since." He also talked to George.

Neither of us, you know, actually did anything about Joe's drinking. He had to do it himself. But he did come of his own volition seeking help, and he did go out and attend meetings and read literature, and he is one of the most highly successful taxi drivers that I know, making anywhere from $12,000 to $15,000 a year.

So AA has paid off for Joe.

A PARTICIPANT. The idea of hitting bottom is pretty understandable, and Jan described it very vividly in a very few words when she found her moment like this.

I have never heard of such a moment being described with AL-ANON, and in my experience the spouse of the alcoholic has an insidious parallel disease that is almost as worthy of naming as alcoholism.

Now, I have never heard anyone mention such a hitting bottom for the spouse of an alcoholic, and I have had practically no success in getting either spouse or parent or child of an alcoholic to look into the AL-ANON group.

WILL. I don't think AL-ANON is stressed enough. A friend of my sister said she could not have got through her husband's drinking and subsequently being found dead in a cheap hotel in New York. Connie went to AL-ANON regularly and said it was a real help to her.

I think the spouse or any member in the family of a practicing alcoholic has to realize that his or her life is becoming unmanageable, just as the alcoholic's is becoming unmanageable. An alcoholic who is drinking affects the lives of about 13 people around him.

So the wife or husband of the practicing alcoholic or the chil-

dren have to realize that this drinking is affecting their lives and perhaps should go to AL-ANON or AL-A-TEEN.

In talking to people on the telephone, and again, this is only my way—Jan's is different, and George's is still different—but if a woman calls about her husband and says, "his drinking is driving me crazy, what do I do?" I suggest AL-ANON, because, after all, if she would get so exercised over somebody drinking, she reaches a point where she is no good if a real crisis comes along.

So if anyone realizes that somebody else's drinking is making his or her life unmanageable, then I think he or she should seek help in AL-ANON or AL-A-TEEN.

When I was drinking alcoholically, my parents didn't know about it. They were dead, thank goodness. But I was affecting my sister's life. I was affecting my editors' lives, my illustrators' lives, the people here in the Book Guild of Washington, and anyone that I was closely associated with.

So to some degree I was making the lives of all these people unmanageable, which now of course I realize I had absolutely no right to do.

A PARTICIPANT. I guess the point is that I don't believe that I can tell the alcoholic to go to AA, and I know I can't call up AA and say, "Look, I've got this guy here." In my book it just doesn't work. He's got to go himself. So, you wait until he's ready to go, and he goes, and whatever you can do to help him make up his mind to go, you do. But you don't do anything to him or at him.

When you are dealing in an industrial situation, you can give this help a little more overtly.

But, when you know darned well that you have got two people in mortal combat, the alcoholic and his wife, you know that AL-ANON would do her some good, you're in the same position. You can't get to her though, and, of course, you can't say, "You go to AL-ANON," because that doesn't work any more than it does for the alcoholic.

WILL. Jan, would you like to see if you could shed some light on the woman?

JAN. I don't know if I can shed any light, because so often we encounter spouses who think this is the alcoholic's problem, that it's not the nonalcoholic spouse's, that he should do something about it, that it's not their concern.

Women have called and said they have gone to AL-ANON and it was a gossip session or they have indicated that they are just as sick as poppa and might be largely contributive to his drinking.

There are some women who call to whom I feel like saying, "If I were your husband, I'd be drinking all the time."

And usually these are the AL-ANON refusers. They are probably afraid to go because the AL-ANON ladies would tell them just this: "You're making a vast contribution to his drinking."

And I don't know how you motivate a husband or a wife to seek AL-ANON. They call, and they want you to give a magic solution to their problem of what to do with him, where to put him. All we know is our own story.

WILL. Thank you, Jan. Don't go away. Give me moral support.

You know, I'm terribly sorry for all of you people who are up against working with a practicing alcoholic. Because, alcoholism is baffling, it's cunning, and it's insidious, and most practicing alcoholics have what I consider a horrible illogical logic. Seemingly they can make absolutely good sense, though, upon reflection, you know all the time it isn't sense at all.

They are always a few jumps ahead of you. And to illustrate this, I have a friend here in town, a woman, who was a problem drinker and the despair of her family. They wanted to get her sober enough for her daughter's wedding. So, they sent her to her sister in Europe, thinking that sister would look after her.

And, of course, they searched her room, and they searched her luggage, and she still continued to get drunk. But they never thought of searching her sister's room where she had stashed her liquor. So, you see, I'm sorry for all of you who are trying to work with the practicing alcoholic, because we are con men and women. We can lie faster than you can possibly think about.

Jan said her moment of truth came when she was about to write a bad check. I had the great pleasure of going into my bank yesterday and paying off two notes, and this is the very bank which once sent me a letter saying that my account wasn't satisfactory.

You get into things quite by accident. I like to gamble too, and I used to go and play the slot machines over on 301. And innocently I had a check bounce, and I went over about it and got quite exercised about it, and they said, "Well, don't worry about

it. It takes a week for a check to clear between Waldorf, Md. and Washington, D.C."

Now, I had never known that, you see. So, naturally when I ran out of money, I would write a check. Now, this is sheer, sheer alcoholic thinking.

I would go over on 301, partly drunk, knowing I was going to get drunker. I would ride along saying to myself, "If F. Scott Fitzgerald could drink and was a writer, why can't I?" Of course, look what happened to F. Scott Fitzgerald. And I'm here talking to you.

But you really have a hell of a confrontation when you are going to try to help the alcoholic employee, unless he wants to be helped.

We go through this. Jan is on the desk at AA, George is on the desk. And I am on the desk. And we go through this two or three times in each stint.

Somebody calls or the individual himself calls and says, "What do I do?" And you tell him what to do, he doesn't want to do any of it, and he isn't going to until he is ready.

JAN. I'd say this, Will—that trying to help an alcoholic is difficult because you like them. I have met wonderful people in AA, and I know wonderful people who are still struggling with the bottle. They are very likeable.

And I think that one thing that is very, very difficult to do—and it takes real love—is the direct encounter: "You're lying." Because you don't know what the reaction is going to be. But you have to be willing for this.

I complained to my minister who once told me I was too hard-boiled with people, I said, "Well, I want you to know that I got fed to the teeth with people who permitted me to lie to them." I knew they knew, and they knew I knew, and it was just a little game we played, and they couldn't bring themselves to tell me what a liar I was, and they postponed my getting close to myself and finding out. This I can't do anymore.

Dr. SIEGEL. What right things and what wrong things, in your experience, do doctors and nurses do in their relations with patients who are alcoholics? I think you have touched on one. You might want to elaborate on it.

Is this a problem you have found in your own dealings through your lives with doctors and nurses and their dealing with you?

JAN. I avoided doctors because I was afraid to be told that I'd have to cut down on my drinking. And I wouldn't have told the truth anyhow. The classic answer is, "Oh, I have had a couple of drinks." But you mean a couple after the first 200.

Well, my sisters and my parents, my husband, my friends, these were the ones I wanted to fool, and I didn't want them to make any personal remarks to me.

WILL. That isn't quite what you mean.

JAN. No, but it might come better from a doctor, a nurse, or somebody I would really believe was genuinely concerned about me and wasn't judging and would appeal to whatever assets I had, if any.

WILL. My doctor is interested in helping alcoholics. In fact, I have had him to a meeting. And he calls me to help. You see, it's the business of not quite understanding how the program works, which nobody understands completely. Remember, we have been down the road ahead of the man or woman who comes to speak to us. And we sound at times extremely tough to the outsider.

But if they are repeaters or "slippees" there comes a time when you have to get tough. Somebody here mentioned this this morning. I think you did, Professor Trice. There comes a time when the boss gets tough, the wife gets tough, the doctor gets tough. You actually have "crisis confrontations."

Sometimes you can speed it along. Other times the person has to reach the point of desperation.

My doctor asked me the other day does a patient with whom he is working have to lose everything. I said, "No, he doesn't have to lose everything. But he may have to lose his wife, job, friends, the whole works before it gets through to him that he has a problem."

Professor TRICE. Do you people find this is one of the most difficult points to get across? We do anyway. We talk about crisis precipitation, constructive coercion. These people say "damn inhuman! How horrible. You should be helping somebody. You're clobbering them."

I find this one of the most difficult points to communicate in any kind of situation. People will hear just about everything you say except that. They just don't want to do it.

WILL. As I say, my doctor asks me, "How tough do you get?" And he found he had a patient who was conning him into prescribing some kind of cough medicine. Of course, the cough medicine was loaded with alcohol.

So then he cut off that particular kind of cough medicine.

We are a very devious bunch. We can figure out ways to get cough medicine and codeine, and you can drink vanilla extract, and lemon extract has more alcohol than vanilla extract.

You know, you can drink all these things and get a large charge out of them. But I wouldn't.

Because a Washington man drank some men's cologne a year ago. Why—I don't know. Maybe he didn't want his wife to know. Maybe he got his bottles confused. But when his wife found him, he was immobilized.

And at first everybody said, "Isn't it lucky that she found him before he died?"

Well, this particular cologne has some sort of a property in it that has a paralyzing effect, and this man has lain in bed for more than a year now paralyzed. He opens his eyes, but no one knows whether he knows what they are saying to him.

I'm not sure he is lucky. But some are lucky. They are the ones who—for whatever reason—constructive coercion, a disaffected wife, or a shock of some sufficient magnitude—have stopped drinking. That's what all this is about. And sometimes you just have to be tough—very tough. But maybe that's the way you save a life.

Community Resources

Paddy Cook

(Mrs. Cook is a member of the staff of the Washington Area Council on Alcoholism, a voluntary health agency supported by the United Givers Fund and contributing members.)

We have three main purposes. The first is in terms of information and education, to erase the stigma surrounding alcoholism in the community. This means consulting with groups wherever we are called in, sending literature, making speeches, holding discussions, showing films, etc.

The second is counseling for referral to treatment resources and education and information to families, to employers, to friends, to associates, and to alcoholics when they call our agency.

And the third is as a community catalyst to promote proper treatment facilities for alcoholics through legal and legislative channels. Primarily I think this agency has been working in that direction for the past 2 or 3 years.

We have been very instrumental in having the law changed in the District of Columbia from handling chronic court offenders or skidrow alcoholics as criminals, to handling them in the public health area.

This, of course, is only part of the problem. About 3 to 15 percent of alcoholics are visible to the public eye, the people who are littering the streets or who are homeless men with an alcoholic problem or who are unable to support their families. Of course, you are primarily concerned with the other percentage who are still employed, still living with families, still with many community and social ties.

We get calls in the agency from every stratum of society for various kinds of problems; how to find a nursing home for a mother who has been an alcoholic for a good many years, and for whom treatment has not been successful, and who needs care in her old age; walk-in's from the street in various stages of withdrawal who need immediate detoxification. Daughters or mothers or wives who are concerned about a member of the

family who is drinking and who are just beginning to face the problem of alcoholism that is disrupting their family in various ways.

We try to keep track of these things and focus the community attention on the greatest areas of need in terms of treatment resources. We maintain a directory of resources for alcoholics in the metropolitan Washington area, and we use this primarily as the basis for our referrals.

We do some counseling for referral. If the person is not ready to accept or we can't immediately determine what kind of a referral he would accept, then we have two or three interviews with that person before a successful referral is made.

We maintain lists of private doctors, psychiatrists, psychologists who are experienced in treating alcoholics. We also know a number of ministers who are experienced and to some degree mental health-oriented.

Sometimes we may refer the family to a child guidance agency or to a family and child services agency, if that seems to be the piece of the string that we can get hold of and that they can accept at that moment.

In other words, not all of our referrals are directly in terms of the alcoholic problem itself. It may be to another agency, a legal agency, for instance.

A PARTICIPANT. Is it possible that your agency would have anyone available to drive a woman to her first visit to an AA meeting?

This is a very realistic problem. I worry about alcoholic women who are living alone in an apartment in the heart of Washington and I am asking them to go to their first AA meeting. After they get there, they are probably going to make contact. But this initial trip by this lonely woman in an apartment can be very difficult for her.

Mrs. COOK. We are open 9 to 5, and we have four people on the staff. However, we have boards and committees, and we have an action committee, for instance, which consists of a number of women, and there are members of AA in that committee.

I think if you called our agency, we could probably make contact with an AA person who would assist her to get to the first meeting—if the woman is willing.

I mean that I don't think anybody will want to go and drag her out of an apartment.

A PARTICIPANT. When you refer to your agency, does the person have to be a resident of the District of Columbia?

Mrs. COOK. No. We serve the entire metropolitan Washington area. We are an affiliate of the National Council on Alcoholism. About 70 affiliates are scattered all over the United States.

But we often receive requests for assistance from a relative here about someone in Wisconsin, for instance. We can help the family get in touch with a council or treatment facility close to the problem.

In the case of a family that is just beginning and is very tentative and doesn't even want to give you a name over the telephone, we can send them something and then have them call back in terms of exploring further into the problem.

I'm sure you are all aware that alcoholism is not something you solve in 10 minutes with most people, particularly when the family is just beginning to look at this as some kind of an illness and not a moral or judgmental problem.

Dr. SIEGEL. One thing you mentioned interested me. You say you do maintain or have access to the names of physicians in the area who will deal with alcoholism in their practice?

Mrs. COOK. Right.

Dr. SIEGEL. This is a problem in the health unit; the individual who for one reason or another does come in and is willing to accept referral to a physician, but either doesn't have a family physician or indicates he doesn't have a physician willing to deal with his particular problem.

I think this is a valuable service.

Mrs. COOK. Right. We find that some physicians are not willing to accept the patient or to go beyond the immediate physical problem that is presented to them.

The physician may treat the person for whatever the symptom is without going further in getting at the alcoholic problem.

So that often a person has been under treatment by his family physician for some time without ever having had indicated to him that the real problem may be the alcohol that he is consuming.

And, of course, from our point of view, the simplest part of treating an alcoholic is to get him sort of patched up. It is going beyond that into the problems causing his drinking and into the whole progressive illness itself and getting him to accept it that is difficult.

You can send somebody in and have him dried out and returned to the community—the same situation, the same job, the same way of handling his troubledness. And he is going to go right back to the same process a number of times most likely.

A PARTICIPANT. Have you had any success or do you have any clever tricks for getting the spouse, male or female, of the alcoholic to an AL-ANON meeting?

Mrs. COOK. No clever tricks. Just lots of times a fairly blunt appraisal of the facts. If it's been going on for some time, there is usually trouble in the marriage. The wife will have as much responsibility for determining her role and reassessing her handling of her husband, since, whatever has been happening, they have each been picking up patterns of responding to each other, to the job, whatever the situation is that has become unhealthy. This often takes some kind of an outside evaluation, whether it's through AL-ANON, or through the wife going for therapy or for some kind of counseling herself.

We are not trying to say, "You're just as responsible as he is," in a punitive way, but that, "You both have a role to play in this problem, and you can both relearn or reevaluate what is going on, and preferably with some outside, fairly objective opinion."

Dr. SIEGEL. It has been my impression generally that one of the cultural ground rules for a work organization is you don't invite contact or get involved with the family.

So I think that in our health unit there is very little contact with family generally and as to supervisors and the work situation, there is probably even less contact with family.

Now, some of you may have other experiences. I think this is a general rule. We don't have family contact in the context of what we generally do.

Mrs. COOK. In other words, you are there, one step away from the supervisor, to make some sort of at least tentative diagnosis of alcoholism or a problem, and then refer them on for further treatment?

Dr. WEILAND. Well, I think you have to keep in mind what the health unit is and its responsibility. Perhaps others here could spell it out for you better. But it is a matter of the responsibility for health maintenance and early diagnosis and evaluation rather than taking over in any way the role of community agencies or private physicians or other people.

Dr. PHILLIPSON. This hypothetical lady coming to you with the problem of her husband drinking—do you take down much in the way of data from her as to where her husband works, et cetera?

Mrs. COOK. To some degree. It's very individual. We do have a form sheet, but we do not always fill out everything on that sheet. In determining the referral that is most appropriate for that person, you pick at whatever string is loose.

Dr. PHILLIPSON. What I'm really getting at is this: I was talking yesterday about the means of finding out the size of the problem. As we already know now, the health units here don't, rather by custom, deal with the employee's spouse. They don't see the wife. You may be seeing the wives of Federal employees who we don't know have a problem.

Mrs. COOK. Right. We are working at two ends of the same question I'm sure.

Now, what should we be doing in this area? Yes, we do get wives who say that their husbands work for a government agency. I can't be any more specific than that. But our tendency is not to involve the government agency.

Sometimes we get referrals from health clinics in private industry, and then we are working more in the line of the job and using that as the area where we can get the person involved.

But in terms of when the wife calls and she may say her husband works for the bus company, unless we actually know what the policy is and have worked with somebody there, our tendency is not to go to the company and say, "We know you have got a problem. What can we do to help?"

But when we make a referral to a public health department clinic, sometimes they do work directly with the spouse or the employer, as they get into the details of the problem.

Dr. PHILLIPSON. Do you get many situations where the wife has come without the husband's knowledge and doesn't want the husband to know she has come?

Mrs. Cook. Many times the wife makes the first opening ploy without the husband's knowledge. We try and get her to go back and talk to the husband directly to begin immediately with the problem, to say, "I have come."

Sometimes the way to get to the husband is to get the wife to seek help, to say, "Look, you've got a problem, but I'm having a problem too, and I'm going to take care of mine, so I'm going to my therapist tomorrow." Or, "I have just been to the Council on Alcoholism."

Many times this will bring the husband in 2 weeks later, because she is reacting in a different way than she has been doing. Either she has been dominating him or she has been getting all the black eyes, but suddenly she's doing something different, and this may be enough. Lots of times the man will then come in.

Of course, we are at an advantage. When they call us they are calling an agency which has that tag name of "alcoholism" included in it. And they have gone that far in recognizing that this may be the source of some of their problems, whereas when you are seeing them I presume that they have not made that much of an assessment of themselves or that this could be a way of interpreting it.

A Participant. What do you do with this information?

Mrs. Cook. We collect it sporadically, because the agency has, as I said, for the past 3 years been more concerned with collecting statistics on court offenders and working in the area of legislation, so that there was a large gap.

We are now collecting it. It should be documented and more carefully researched in terms of what is happening.

A Participant. If you send this person to another clinic on a referral basis, do you give this clinic this information? Or do they go and get the information they want?

Mrs. Cook. Most of the time they go and get the information they want.

A Participant. You do not give this information to the clinic? I'm trying to see how much of this what we think would be confidential information goes to someone else.

Mrs. Cook. Sometimes, say, in referring to a private psychiatrist, we may say to the person, "We would like to refer you to a particular man we are thinking about. Do you mind if we call

him and discuss whether he would have room for you or whether he could fit you into something now?"

In other words, we wouldn't go without permission to somebody and offer a name for referral.

Also, we try and get the person who is seeking help to go on his own to the treatment resource.

So we primarily would be asking them to go on, giving them the information with which they could go on for treatment.

A PARTICIPANT. What do you think about communications between your agency and a government agency about wife and husband? What could come out of this do you think?

Mrs. COOK. I don't know, except that it would depend upon what the main source of the problem is. If it seems to be in a marital situation, you are probably not going to have too much success. It depends on how valuable the job is to the man and how much trouble he is having with his wife, and if that is the source of the friction and the problem, then, probably success is not going to come unless both of those people get involved in something.

A PARTICIPANT. Of course, we don't have any type of cross-communications, but I just wondered what could be the advantage if we happened to have it. I'm trying to think in terms of what we can do to help.

Mrs. COOK. Let me ask you what your feelings are on that.

A PARTICIPANT. I don't know. We're too tied up with confidentiality of all of our records. But it seems to me that if the agency is having this problem, we know about it, and if we would have a call from another health agency, there would be possibility of communication.

It may be that the wife should go home and tell the husband, "I have gone to this agency. Now you go to the nurse and discuss it, and then she can call the person." Some way of cross-communication.

I think it would be a good idea, really.

Mrs. COOK. I think it's a good idea to involve the significant people in the person's life. But you have to do it without violating confidentiality.

You do have to stay with the client that you are working with all the way through on this kind of situation.

We are not really involved in treatment either, just as you aren't. This is part of the problem.

A PARTICIPANT. Personnel can call a family in and discuss a problem like this with them.

Dr. SIEGEL. I think personnel rarely does, realistically.

Mrs. COOK. Where do you send most of the people that you see? To whom do you refer them, if you are not doing the treating?

Dr. SIEGEL. A private physician. We have stayed out of a lot of areas which take more than the private physician, like your community resources. We diagnose the diabetic, the person with visual defects, and the referral is usually made to an M.D. practicing in the community, which is in a way a relatively easy type of referral to do.

Mrs. COOK. Right. And then how much follow-through is there? Do you check to see if the person has seen him? Do you find the physicians to whom you refer these people work along with you also in getting them involved? This is our problem.

Dr. SIEGEL. It varies. It's probably no different than any American community. Highly varied.

A PARTICIPANT. I don't think a private physician has the time that you need to work with an alcoholic . I think they want to refer them to an organization also, say AA or some rehab center, more than trying to take care of them themselves.

Dr. SIEGEL. I think your question was how does a private physician work with us? And in the Public Health Service we have done really very few referrals to private physicians for alcoholism. We don't have any basis of making the judgment as to what is the effect.

Mrs. COOK. There is a group here that has a psychiatrist and a couple of internists on the staff, and they also have an admissions policy at one of the local hospitals. And they work closely with AA when someone is really on a bender and is having a lot of problems. This may involve 20 phone calls just getting across; "Put on your clothes. Call the taxi, and put on your clothes."

And then 20 minutes later, "I know you can make it. Put on your clothes."

You would be surprised. It can go on for about 4 hours just getting the woman dressed and in a taxi and to the physician.

We feel safe if we have gotten her to a physician whom we know will get her admitted to the hospital and will send somebody to see her during the time she is in the hospital and try to get her involved in an AA program or to a psychiatrist or make some further assessment of it.

And that is always the problem, because she may well go into that hospital and get sobered up, and come back and go through the whole procedure four or five more times before she finally begins digging in to the basic problem, which is tough.

Dr. SIEGEL. The focus of this meeting has been on the problem. You deal with the disease as the disease, i.e., the therapeutics, how to get the person with the illness better. But we will have to face in our health unit activities the question of what we can do in terms of primary prevention.

Mrs. COOK. Right. There are lots of people who think the skid row alcoholic is pretty unsolvable and we will have to provide community resources to support him rather than to deal with him as a criminal.

And as you back up, the alcoholic is going to be more difficult to treat than working on an area of primary prevention.

You may not be focusing on this, obviously, but it may be something that has to come about before you have much success.

Dr. SIEGEL. Can we take some comfort that Washington, as far as the United States is concerned, is pretty favorably situated in terms of what the community does have available here for this problem?

Mrs. COOK. We need much more. We are very innovative, and I think that the focus in the United States is going to be on what happens. And I think that as community people, it's very important to become aware of what is happening in the community and supporting more treatment and facilities.

Recent Civil Service Commission Recommendations

Frederick F. Bell

(Mr. Bell is an Occupational Health Specialist, Division of Occupational Health and Safety, U.S. Civil Service Commission.)

Words are problems. I think that is one of the keys to the Civil Service Commission's view on alcoholism.

Can you visualize attending a staff meeting without words? Can you imagine going into your boss' office and listening to music and looking at pictures?

Words are necessary. But they are only symbols. They have no properties. The word "bucket" doesn't hold water. It just represents a contrivance that does. We send out word symbols when we talk, and we get into trouble if the fellow that we talk to doesn't receive the same meaning that we transmitted. So whether or not our words are "clean" or "dirty" depends on what the receiver perceives them to be.

Now, what has this to do with alcoholism? And why should I speak to you about semantics when I hope you are interested in the Civil Service Commission's view on alcoholism?

If I say the Civil Service Commission wants every agency to have a vigorous alcoholism program, we get into all sorts of problems. So, since general semantics is a search for the significant, I think I had better try to introduce you to the "significant" the Civil Service Commission has identified.

The Commission is the personnel arm of Government. It is in the people business. It finds employees. It recruits them. It tries to train them, provide career ladders for them, and make certain they are treated fairly and equitably. It retires them. It replaces them.

And it does those things with a dual outlook. First, it has a legitimate and real concern for the employee. It wants to keep the employee happy. If it doesn't keep him happy, Government won't keep him at all.

Also, it has a concern for management, and in many ways it tries and sometimes succeeds in aiding agencies to optimally use employee resources.

One of the ways it is trying to do this is by exhorting, prodding, explaining, and convincing agencies to maintain employees in the same sense that they maintain typewriters, cars, and computers. Here is where our signals may get crossed. I'm speaking of occupational health.

But, when I speak of occupational health, I may mean something entirely different than you as health professionals recognize or than a private in the Army or a secretary in the typing pool does. So, therefore, let me try to convey to you what I and what the Civil Service Commission mean when we use the symbols "occupational health." Occupational health to us is not one thing. It is not a health unit. It is not a first aid cabinet, a screening exam, or a physical exam. Rather, it is all of these things, plus a myriad more.

We view it as preventive health services, emergency health care, effective environmental health programs, vital safety programs, physical fitness programs, occupational mental health programs, and much, much more.

Wouldn't Government be silly if it hired a fellow for $10,000, and then poured another $10,000 into training him and, over the years, let him acquire $100,000 worth of expertise and then lost him because it would not spend $25 to find a cancer or glaucoma.

I don't think that anyone in this room would disagree that it makes sense for management to try to help the employee solve whatever makes him a problem rather than losing its investment in him.

Supervisors have been doing this since the first supervisor. Now, hopefully, management is going to help them. Hence, Federal occupational health programs. Hence, Federal alcoholism programs. I hope that you see this view, this management outlook, that is so totally different but yet not contrary to what you as professional health people must hold.

Now, also in occupational health, and still under the Civil Service Commission's definition for maintenance of employees, is the idea of preventive programs to deal with troubled and troublesome employees. The logic is the same. If a supervisor

has a problem employee, basic economic good sense says that a good employee who turns sour is worth such attention, that is less than the cost of replacing him.

Accordingly, on an economic basis alone—and certainly not the only considerations are economic—the occupational health program is justified.

Now, let's get into the Commission's view on alcoholism programs. "Alcoholism" means several things. I am not going to match definitions or details with Harry Trice, Gus Weiland, and the rest of the experts that have been before you, but I do want to point out that "alcoholism", or the several "alcoholisms", mean to medical professionals something different than they mean to most people.

To a nonphysician—and I'm sorry to say to some unenlightened physicians—the term "alcoholism" means a drunk, usually a no-good drunk.

You might find interesting the fact that of all human concepts—love, hate, money, things, et cetera—the concept of "drunk" has more symbols than any. For a subject that many still hold as taboo, it is interesting that, while most concepts have only a half-dozen to a dozen synonyms, the "Dictionary of American Slang" lists 321 slang expressions for the drunk concept—321—and that does not include nonslang words such as "alcoholic", "intoxicated", "inebriated", "under the influence", et cetera. Therefore, an "alcoholism" program could be called a "spifflicated" program or a program to deal with employees who are "basted", "behind the cork", or "over the bay."

For the sake of clarity, though, let's agree that "alcoholism" means something specific and that its meaning is medical.

If we grant this, then we cannot have an "alcoholism" program. Obviously, Government supervisors are not physicians. Supervisors cannot diagnose alcoholism. They can tell if an employee is a problem, and as they delve into what type of a problem he may be, they can tell or at least gain a pretty solid hunch that he is a problem to them because he drinks differently than most people; because he is a "problem drinker."

Therefore, although Government cannot have a practicable program to control or to deal with alcoholics, it can have one to deal with problem drinkers.

Now, we have taken considerable time to set the stage. But, I

think that we can now communicate. Perhaps our symbols will be better attuned to one another.

We should have clearly in mind that the Civil Service Commission's role is directed to helping both management and employees, and that the Commission's interest in drinking problems is exactly the same as the interest it has in heart attacks. It is focused in the broad area of occupational health and on into the broader area of personnel management. Now we can talk about the Commission's suggestions to agencies on how to deal effectively with problem drinking among employees.

In November 1967—a year and a half ago—Government first officially recognized that some of its employees might be problem drinkers, alcoholics. I will use the two terms interchangeably now that we know what we are talking about.

At that time a few agencies, a handful, had going alcoholism programs, Social Security Administration in Baltimore. Navy had a program. The Department of State has a program and so does part of the Army. At that time, the Department of Labor was developing a paper program that ultimately was put into effect.

But to most of the agencies and to 99 percent of the 3 million employees, the very thought of alcoholism was taboo.

In November 1967, the Commission sponsored "A Conference On Drinking Problems." It brought experts on alcoholism from industry, education, medicine, organized labor, and Government together with representatives who had been designated by each agency head to learn about problem drinking and, further, to learn what could be done about it.

The report of the conference was the publication, "The First Step." It presents the thoughts and considerations of many of the key authorities on alcoholism in this country.

Over the next year the full tapes of the conference were condensed, sifted, distilled if you will, and the distillate gathered into a second publication released only in mid-February 1969. It is titled "The Key Step."

Briefly, "The Key Step" contains the Commission's advice to agencies. And that advice is based on the opinions of our experts from the conference.

First, agencies should issue a public policy statement covering recognition of problem drinking as a health condition, guarantee-

ing freedom from invasions of privacy, and outlining the program that will be conducted.

Second, agencies should establish an organization within the agency to administer the program. This doesn't mean new people. The organization would be headed up by one man at headquarters level, hopefully the agency's occupational health officer.

Then, there should be a "program coordinator" in every agency installation around the country. That program coordinator would be the real key to the success of the program. He is the person to whom supervisors will turn with their problem drinking employees.

He will also maintain liaison with community facilities, arrange for referrals, including referrals to the health unit if there is a health unit, and he will arrange for referrals to community agencies.

Then also as part of "The Key Step" program—and this is rather innovative—sick leave is to be granted for purposes of attending a rehabilitation program connected with alcoholism.

The programs, as I am sure Harry Trice told you, will use the "raising the bottom" or "constructive coercion" techniques, because the employee is a problem employee and his job is in jeopardy.

When communicated to all agencies and installations across the Nation, I think the program will work. It helps everyone, the supervisor, the agency, and the employee.

I'd like to go on to tell you how I think medical professionals can help in getting this program across.

Our largest job is not ferreting out alcoholics. From a management standpoint, we don't want to dig into the lives and habits of employees who are doing their jobs well. Instead, we want to communicate with those employees. We want to educate them so that "no-good drunk" doesn't pop into their minds when they hear the term "alcoholic" or "problem drinker."

If we can get across to the employee through conversation, Harry Trice's and others' writings and literature, what alcoholism is and its results, the way it progressively rots the victim until he is better off dead, and usually is, then maybe he will keep an eye on himself. Maybe if he knows some of the signs of developing alcoholism and recognizes them in himself, he will

seek aid—if not from the Federal program, from AA or from a community resource, medical or otherwise.

That, in my opinion is our most important job—communicating with the non-problem employees. If we can accomplish it, we will find that troubled employees will volunteer for our alcoholism programs, and they will seek us out, and when that happens consistently, our job will be pretty well complete.

One of the most important ways medical professionals can help is to talk about alcoholism to groups and individuals. But don't talk to them from the pedestal. Come down. Don't use terms like "detoxification." Recognize in your own mind the non-medical aspects of alcoholism and help your employer and the employees that come to you for guidance by spreading information about it.

By "nonmedical," I mean several things. To be specific, the basis for Federal alcoholism programs is cost benefits, the same as for any program. The fact that employees benefit from occupational health programs, including alcoholism programs, is quite a nice coincidence but isn't the main factor.

When a supervisor is aware that one of his employees is not pulling his share of the load, whether it is because of his inability, indifference, health, whatever, the supervisor must act. How he solves the problem—by dressing down the employee, by buoying him up, by referring the employee to a health unit or to someplace else, or by withholding a step increase, or by initiating disciplinary action—is irrevelant. The work must get done, and the supervisor must see that it is done.

The alcoholism program is one way to help the supervisor get it done. Accordingly, the universality of "The Key Step" program is a very important thing. Everyone has a supervisor. We want the supervisor to take action, whether the affected problem employee is a line employee or a top management person.

I mentioned "The Key Step" program's policy statement. If I may, let me take 2 minutes to read it and then I would like to open a discussion period.

We are suggesting that agencies issue something like this:

"Alcoholism is a serious and expensive national health problem. The Federal Government probably has a lower rate of alcoholism among employees than does industry. Because of the Government's size, however, it is probable that, in absolute num-

bers, there may be thousands of Federal employees who have drinking problems. Accordingly, this agency recognizes that alcoholism is an illness that may affect, now or at some future time, the health, work performance, and conduct of some of its employees. This statement establishes, within the occupational health program, a policy and program to assist employees whose drinking habits are causing or contributing to job difficulties.

"This agency is not concerned with the private decision of an employee to use or not to use beverage alcohol off the job. However, when its use impairs his work performance, attendance, conduct, or reliability, it is the responsibility of management to take action.

"The alcoholism program introduces nondisciplinary procedures under which an employee with a drinking problem is offered rehabilitative assistance. If he refuses such assistance, or if the course of rehabilitation fails to achieve professional expectations, regular disciplinary procedures for dealing with problem employees will be used.

"This agency will:

"Remain neutral on the decision of its employees to use, or not to use, beverage alcohol while not on duty;

"Implement a formal program to identify and offer rehabilitative guidance to employees whose drinking habits have resulted in job difficulties, including poor attendance and conduct;

"Recognize that individuals who suffer from alcoholism are entitled to the same respect, confidentiality of medical treatment, and records handling as employees who suffer from any other health condition that affects job performance;

"Conduct all phases of its program on alcoholism in the highest professional manner;

"Grant sick leave for employees to participate in approved rehabilitative programs; and

"Encourage the use of established community resources and facilities, as available, as sources of rehabilitative care."

"The Key Step" goes on to describe the organization that I previously mentioned, and then to give advice on implementing the program. Essentially it is a very simple program.

The reactions to it from industry and from all participants in the conference on drinking problems have been unanimously favorable.

One of the areas in which I expected to hear criticism but have not was that adequate facilities are not available in the communities. I might comment on that even though no objections have been voiced. Government is not in business to rehabilitate its employees. Some agencies have rehabilitative missions, but the Corps of Engineers, for example, is not interested in performing rehabilitative services for its alcoholic employees any more than it is interested in providing surgeons to remove gallstones from a crane operator. It, like most agencies, will rely on health or rehabilitative resources in the community.

To say that they are insufficient or inadequate is much the same as saying treatment facilities for orthopedic cases are inadequate.

The answer from our standpoint is: Use what is available. Go where adequate facilities are available. Or work to establish adequate facilities in the community or in your own agencies.

The Government, as a rule, does not provide medical treatment to its employees. Instead, it shares the costs of a health benefits program. All health insurance plans now provide some benefit for alcoholism. Accordingly, the employee is usually well able to pay for the service he needs if money is a consideration in his rehabilitative program.

Additionally, voluntary health agencies and facilities will be and are intended to be a key part of our suggested program.

I think we are now ready for questions.

Dr. EDERMA. In one sense I don't quite agree with you. For example, when we go after diabetes, let's say, we know that the diabetic can be handled, because there is some consensus about what to do about a diabetic once he is detected. And we can refer him to a private physician or medical facility.

In alcoholism, this is not that clear. And if you listen to the speakers even this morning from the community, they already have in the area, for example, some 5,000 chronic alcoholics that need a place to go and probably don't have a place to go.

And if you think in the Washington area we have about—What? 250,000 civilian employees?

Mr. BELL. Yes.

Dr. EDERMA. And if we have a very active program in trying to find alcoholics and to detect them and trying to do something about it, sooner or later we will defeat our purpose.

Mr. BELL. Well, this is assuming that most of the Government populations are drunks. I'm not sure that this is true. I'm not sure that our problem is even the 3 percent figure that is bandied around.

Secondly, in the Washington area there are more than 150 AA chapters. There are many AL-ANON chapters, and a few AL-A-TEEN chapters.

Theresa Abbot's group has quite a thick directory of private sources of rehabilitative assistance. With the insurance programs, I think that these should be used.

I do not deny there is a problem. I think that we are probably more fortunate here in Washington than most areas. I am saying that, although it would be gratifying for every agency or group of agencies to develop a potential for handling alcoholism in its health units around the country, preferably the Division of Federal Employee Health as far as I'm concerned, I don't believe that the identification and educational facets of an alcoholism program should be hampered significantly by the lack of that achievement.

I'll supply my own question here. I heard one about the legality or legal problem of supervisors identifying someone as an alcoholic. Of course, the supervisor doesn't identify anyone as an alcoholic under our suggested program. The problem employee is about ready to get fired or, at least, to receive some sort of discipline. Instead of that, the supervisor thinks that there may be a problem, and he refers him on for competent diagnosis or assistance. That is all.

Dr. PHILLIPSON. When you say he "refers," would it be more correct to say he "encourages" the employee?

Mr. BELL. Yes. Actually, you are confronting the man with a choice of seeking some rehabilitative assistance—"Look, John, I'm going to have to write you up on this, but maybe we can get out of it if you will go up to the health unit and have them look at you." I don't see much problem there. You could offer the employee the choice of having a chance to retain his job—or of discipline.

A PARTICIPANT. You can coerce him.

Mr. BELL. Sure.

Dr. PHILLIPSON. You cannot give him a lawful order, "You will go and see the doctor."

You can say to him, "If you don't go to see the doctor, you may be fired because of your job performance."

Mr. BELL. That's right. But, of course, he should understand that the rehabilitation program will only work to his advantage if it succeeds.

A PARTICIPANT. You speak of giving them sick leave for rehabilitation purpose. How is this to be handled? Because usually these people do not have very much sick leave to start with. They have already used it.

Mr. BELL. You can advance sick leave.

A PARTICIPANT. More than 30 days?

Mr. BELL. This would be according to the regular agency policies on sick leave. I think we can cover our guidelines very briefly here. Probably, a request for sick leave which can be identified as being directly related to problem drinking would arise only when an employee is away from work to obtain treatment for his condition under an approved course of rehabilitation. Granting sick leave or advanced sick leave is appropriate for this purpose. Under other circumstances, the granting of sick leave is subject to existing agency policy.

Dr. SIEGEL. One factor is important to realize. This is a constant problem in Government. There is some general overall Government "corporate structure." Individual companies within the corporation operate differently. And it's appropriate. Because the mission of the Department of Interior is a lot different than the mission of the Agriculture Department, for example. And the way they run their business is different.

So we are going to find this situation where some agencies may say, "No, we can't afford to advance sick leave," and other will.

You have to live with this sort of business. In the Division of Federal Employee Health we serve many different agencies out of a unified health unit. But that's our headache to some degree.

I think the fact we are meeting here is going a long way in what I consider to be making an advance.

I think in the last 2 days we have learned that if the individual with this problem can be motivated to seek to do something about

it, it's a big step taken down the road. And I think there are enough facilities in the community of various and sundry sources.

For example, most diabetics we refer to GP's or internists. But it has also been taught to us that persons who have drinking problems probably are helped by a variety of methods. AA may be for one. The psychiatrist for another. The internist for another. The minister for another. Just a decision, very little support, and the man just decides—the revelation comes. He's going to quit. That eases the referral problem.

Mr. BELL. This is where the health professional can play an absolutely key role. If there is a health unit available, the deciding of the type of referral is most important.

Disability retirement is often brought up. A person cannot be retired on disability on grounds of alcoholism. However, in recent years I believe that in practically every case of an alcoholic whose application was submitted, either personally or by the agency, the Commission found emotional or physical problems that were prime factors allowing disability retirement.

A PARTICIPANT. The issuing of a policy statement is the first step. But I believe there still will exist a credibility gap between the issuance of a statement and the acceptance by the employee.

And since every agency rightfully has the right to regulate its own program, and since the supervisor is the key man, what I would suggest is that, rather than have the agencies train their own supervisors in recognition, that the Civil Service Commission give some type of universal training, so that a third party is involved and the people lose that suspicion of the agency and more readily accept the policy that is offered.

Mr. BELL. There is now under development a reimbursable training program in our Bureau of Training designed for supervisors, not specifically for alcoholism, but to instruct supervisors in how to handle a problem employee, whether his problem is alcoholism, emotional instability of one sort or another, or what. Hopefully, this will be ready for piloting about September. It will be conducted eventually in 10 regional centers of the Commission and Washington.

Yes, Ma'am?

A PARTICIPANT. How would one obtain this particular information?

Mr. BELL. That's really up to the agency. Maybe I can help a little bit. We are building, in the Commission's Division of Occupational Health and Safety, a staff of 10 active people around the country whose sole purpose in life will be to promote occupational health.

Many facets of the subject are not suitable for promotion at the moment because of budget, personnel ceilings, et cetera. But we can promote other areas. If we have our people calling on agencies and saying, "Look, this course can do your people some good," I think you will possibly get there a little easier than you have in the past.

A PARTICIPANT. In your policy statement I believe you used the phrase that there will be a "protection from invasion of the employee's privacy." Do you want to discuss that, how this can be accomplished?

Mr. BELL. This, of course, is a huge area. I can't cover it in the minute and a half I have left. Perhaps I can read a couple of paragraphs from "The Key Step." We say:

"The importance of keeping accurate records of cases handled under the program cannot be overemphasized. Supervisors should document the results of discussions and the actions they take to try to motivate the employee to correct deficiencies in his job performance. They should also record the symptoms of problem drinking in order to assist the rehabilitative experts in charting an appropriate course of treatment for the employee.

"The program administrator should be the focal point for records relating to the employee's drinking problems and his course of rehabilitation. Program administrators should release record information only on a strict "need to know" basis. Records should be confidential. Records containing medical information should be handled according to the prescribed procedures for maintaining medical records. Records created and maintained by the supervisor or program administrator should not be filed in the employee's official personnel folder. Official Personnel Folder records should not include mention of an employee's alcohol problems or efforts to rehabilitate him except as they apply to specific charges leading to disciplinary actions, e.g., "Drinking on Duty."

Again we have an occupational mental health committee with representatives of NIMH, personnel people, Civil Service Com-

mission, Division of Federal Employee Health. Their first meeting is scheduled for next Monday morning. And one of their main concerns will be how to protect the employee from unwarranted invasions of privacy. You will see more on this.